ORGANIZATIONAL PLACEMENT OF STATE SUBSTANCE ABUSE AGENCIES:

IMPACT ON ORGANIZATIONAL PERFORMANCE

August 16, 2004

Report on Phase I Analysis

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ACKNOWLEDGEMENTS AND METHODOLOGY

ACKNOWLEDGEMENTS

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States were given an opportunity to review their own State descriptions and make comments and suggestions, many of which are incorporated here. In addition, senior staff of California ADP, William Ford, Ph.D. of HSR and three expert reviewers made comments and suggestions that are incorporated into this document. Remaining errors are the responsibility of the Avisa Group. The observations and views expressed herein are attributable to the Avisa Group and no endorsement by ADP, CSAT, SAMHSA or HSR is intended or should be inferred.

METHODOLOGY AND NEXT STEPS

Nine States were initially selected for inclusion in this phase of this qualitative study by California ADP and Avisa; these States were selected to represent different governmental organizational configurations and were selected from the nineteen most populous States because California is so large and diverse and comparisons to smaller states would not be appropriate. Structured interviews and follow-up discussions with State Directors and their key staff from each State Substance Abuse agency were conducted on site in three States: New York, Texas and Washington. In the other six States, structured interviews with Directors and their key staff were conducted by telephone. Additional information primarily related to expenditures was also requested from each State. A copy of the discussion guide used both in the telephone and the on-site interviews is appended.

An initiative to add three more States of interest, to conduct additional site visits and to add perspectives from other major constituents in each State has been

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approved by CSAT and is currently underway, with a final report expected in November 2004.

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EXECUTIVE SUMMARY

- State substance abuse services and policy are critical components of State government functions. Undetected, unprevented and untreated substance abuse problems impose significant costs on health care, on other State agencies and on other components of the community. States vary both in the extent of their substance abuse problem and in the prominence of their State substance abuse agencies within the State government.

- In order to implement substance abuse policy and services that will actually achieve the objective of reducing direct and indirect costs of substance abuse, effective collaboration between the substance abuse agency and multiple other State and community agencies is required. This need for interagency collaboration is greater for substance abuse than for almost any other health or human services agency because virtually every public agency has clients with substance abuse disorders.

- To achieve effective interagency collaboration, the substance abuse agency must be highly visible, relatively autonomous and not completely subsumed within an agency that does not fully share its priorities and mission.

- The organizational placement of a State substance agency is one major variable explaining the autonomy, visibility and resources of State substance abuse agencies. Agency leadership and personal expertise and connections of the Directors and key staff also play important roles but they can be stymied if structure does not permit them to exercise that expertise or collaborative initiatives easily.

- One of the most important determinates of agency autonomy, and one that is highly correlated with organizational placement, is whether or not the State agency Director is appointed by the Governor. Appointment of the State agency Director by the Governor confers authority, credibility and status, as well as clearly indicating the priority of substance abuse issues within State government.

- Substance abuse agencies that are in the lower echelons of the State bureaucracy and do not have sufficient visibility, adequate staff or other resources, report that they are simply unable to advance significant substance abuse education, prevention, treatment and policy objectives that are held jointly with other agencies, especially including criminal justice and law enforcement.

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- State substance abuse agencies with high visibility in the State system and a corresponding allocation of resources reported being able to promote effective substance abuse policy through the agency's status, visibility, credibility with a strategy of interagency collaboration. These agencies also report being better able to devote internal resources to the effort required to obtain discretionary Federal funds.

- SSA's that are directly supported either by a drug Czar or where the SSA Director and staff have direct and positive relationships with the criminal justice/corrections system through other mechanisms also reported that they were better able to function efficiently and effectively as agencies.

- Several Directors and their executive staff emphasized the key role of leadership in the success of their SA agency, regardless of its organizational position within State government. However, the exercise of any type of leadership requires resources.

- Substance use and abuse is an important issue in the treatment of those with severe mental illness (SMI) or severe emotional disorders (SED). Collaboration with the State substance abuse agency is of critical importance for State mental health agencies. Collaboration with the State mental health agency is a key function for State substance abuse agencies. However, treating co-occurring disorders is more of a programmatic and clinical issue than an organizational placement issue within state government.

- The significant proportion of clients of a State mental health agency who have substance use and abuse issues may imply to the mental health agency or State government that the ability of the mental health agency to fulfill its organizational mission would be improved if it could simply subsume the substance abuse agency into its operations so as to be able to exert greater control. However, the evidence developed to date in this nine State study clearly indicates that this submersion would significantly degrade the ability of the State substance abuse agency to fulfill its mission, which requires dealing with clients from many other State agencies through extensive collaborative efforts, especially involving criminal justice, in addition to its collaboration with the mental health agency.

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FINDINGS

IMPORTANCE OF STATE SUBSTANCE ABUSE SERVICES AND POLICY

State substance abuse services and policy are critical components of State government functions. This is true despite the relatively small portion of State budgets devoted to substance abuse issues. Among the major sectors that are affected by substance abuse-related issues are public and private health care, public welfare and social services, public safety, accidents and violence, housing, education, adult and juvenile criminal justice and corrections, education, vocational rehabilitation, commerce/labor and economic development. Two clusters of issues explain the disparity between the critical importance of the issue of substance abuse to the States and the amount of direct spending by States on substance abuse education, prevention and treatment services.

First, undetected, unprevented and untreated substance abuse problems impose significant costs on health care and other components of the community[1], including:

1. Primary and specialty health care services and systems, especially including infectious disease and obstetrics
2. Public safety, violence and accidents
3. Child welfare
4. Criminal justice
    a. Law enforcement and the court system
    b. Jails, prisons and parole systems
    c. Juvenile justice
    d. Incarceration alternatives
5. Housing
6. Education and Vocational Rehabilitation
7. Mental health

Second, State substance abuse spending fluctuations, often related to budget deficits or surpluses, may be accompanied by corresponding changes in Federal support, causing a multiplier effect on State spending for substance abuse services. In addition, Federal Maintenance of Effort (MOE) requirements associated with the Substance Abuse Prevention and Treatment (SAPT) Block Grant stipulate that States must keep their State and/or county spending for

[1] Office of National Drug Control Policy (2001). *The Economic Costs of Drug Abuse in the United States, 1992-1998*. Washington, DC: Executive Office of the President (Publication No. NCJ-190636).

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substance abuse education, prevention and treatment at the previous year's level, no matter how large or small that level is, in order to retain the same level of Federal support. States failing to maintain their specified substance abuse State-funding levels are subject to a proportionate reduction in Federal funding under the SAPT Maintenance of Effort Requirements. Several States that Avisa examined have either been cited for MOE problems already or fear that they will be cited, causing fiscal uncertainty that affects planning, operations and interagency collaboration. Thus, reductions in State spending may incur a multiplier effect by causing a concomitant reduction in Federal spending.

Many States provide some substance abuse treatment services as an optional benefit under their Medicaid programs. State dollars spent for services covered by Medicaid are also matched according to a formula by Federal dollars, providing for a second multiplier effect that works in both directions. Therefore, spending by States for substance abuse education, prevention and treatment has an impact on health and welfare disproportionate to its size due both to the mechanisms of Federal support and to the corresponding impact of changes in spending on the direct and indirect economic and social costs of substance abuse and dependence. It is of note that both mechanisms of Federal support work to reduce Federal spending when State spending declines, but only Federal Medicaid support increases when State Medicaid expenditures increase.

ROLE OF COLLABORATION IN IMPLEMENTING SUBSTANCE ABUSE POLICY

In order to implement substance abuse policy and services that will actually achieve the objective of reducing direct and indirect costs of substance abuse, effective collaboration between the substance abuse agency and multiple other State and community agencies is required, according to all of the respondents interviewed. This need for interagency collaboration is greater for substance abuse than for almost any other health or human services agency.

To achieve effective interagency collaboration, the substance abuse agency must be highly visible, relatively autonomous and not completely subsumed within another agency that does not fully share its priorities, requirements and mission. One of the most important determinates of autonomy and visibility, and one that is highly correlated with organizational placement, is whether or not the State agency Director is appointed by the Governor. The State substance abuse agency must be perceived by other agencies and legislative/gubernatorial staff to have sufficient importance, status and clout within State government in order for them to be willing to spend scarce time, staff and effort at a time of competing

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priorities in effective collaboration. This makes it possible to develop and implement effective and efficient initiatives that maintain and optimize SA clinical service integrity and quality, while providing services to SA clients of other State departments. Attracting additional resources through active collaboration also provides the ability to devote resources to the effort required to obtain additional discretionary grant funds from Federal agencies that provide funding for substance abuse services, which in turn confers credibility with other State departments and the legislature.

This review of substance abuse agencies in nine large States indicated that SA agencies that lacked Gubernatorial appointment status, were in the lower levels of the State bureaucracy and did not have sufficient visibility, adequate staff or other resources, were simply unable to advance significant substance abuse education, prevention, treatment and policy objectives that are held jointly with other agencies, including criminal justice. One result was that these State substance abuse agencies appeared to be dominated by other constituencies such as providers and the substance abuse system responded primarily to the concerns and interests of these constituents rather than being able to focus more on the needs of the substance abuse clients and others negatively affected by substance abuse. The organizational placement of a State substance agency is one major variable explaining the visibility and resources of State substance abuse agencies. Agency leadership and personal expertise and connections of the Directors and key staff also play important roles but they can be stymied if structure does not permit them to exercise that expertise or participate in and initiate collaborative efforts easily.

ORGANIZATIONAL PERFORMANCE OF STATE SUBSTANCE ABUSE AGENCIES

This study indicates that State substance abuse agencies with high visibility in the State system and a corresponding allocation of resources report being able to promote effective substance abuse policy. This is accomplished through the agency's status, credibility and strategy of collaboration with other agencies throughout State government that enables the SSA to serve clients with substance abuse disorders who are often clients of other State systems. SSA's that were directly supported either by a cabinet-level drug Czar or where the SSA Director or staff have direct relationships with the criminal justice/corrections system through mechanisms, such as the SSA Director sitting on the State's drug demand reduction council or having professional experience in the criminal justice agency (CA, FL and MI), also reported that they were better able to

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function efficiently and effectively. A summary of these perceived organizational performance measures appears in Table I below.

TABLE I

PERCEIVED ORGANIZATIONAL PERFORMANCE

STATE	SSA DIRECTOR APPOINTED BY GOVERNOR	SUCCESS IN MOE	EXTENT OF COLLABORATION WITH OTHER AGENCIES	ABILITY TO MOUNT SA POLICY INITIATIVES
Florida	Y*	Y	H	H
Georgia	N	Y	L	L
Massachusetts[2]	N	N	L	L
Michigan	Y	Y[3]	H	H
New York	Y	Y	H	H
North Carolina	N	Y	H	M
Ohio	Y	Y	H	H
Texas[4]	N	Y	M	M
Washington	N	Y	H	H

N, Y No, Yes
H, M, L High, Medium, Low

* Director of Florida Office of Drug Control (ODC) appointed by Governor. Director of SSA, who is dually appointed to ODC and the State SA Agency, is not appointed by the Governor

SIGNIFICANT SUBSTANCE ABUSE POLICY ISSUES

State Directors and their staff raised a number of general substance abuse policy issues that were broadly relevant beyond the borders of their individual States. In addition to the specific organizational issues discussed in more detail in subsequent sections of this report, the following significant substance abuse policy issues were emphasized by State Directors:

[2] Massachusetts – Extensive collaboration and policy development within Department of Public Health, focused on prevention mission
[3] Michigan – Problems with MOE requirement prior to reorganization
[4] Texas - Planning for reorganization of State agencies has disrupted collaboration and SA policy development

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Leadership

- Several respondents emphasized the key role of leadership in the success of their SA agency, regardless of its organizational position within State government. Although this attribution of the success of their agencies to the exercise of leadership by the Director and his/her key staff could be partly self-congratulatory, there appears to be a core of truth to this assertion.

- The exercise of any type of leadership requires resources. A Director and senior staff in an agency with severe resource constraints and very few staff members will be unable to devote the resources of the agency to leadership and interagency, intergovernmental activities. Even though such an agency could provide services to clients of many of these other departments, it will, instead, be forced to devote all available resources toward fulfillment of the agency's Federal and State required missions alone because of resource constraints. Although some of these missions require providing services to individuals who are also clients of other agencies, it is only the minimum number of required tasks that can be accomplished.

- The ability to exert leadership is fostered by staff and funding stability and continuity. Agencies with continuity in the positions of the Director and key staff, as well as having records of funding stability, report that they have more ability to be leaders in the State and in combating substance abuse.

- Policy leadership requires agency and staff collaboration with other entities, especially in SA, which provides services to many people who are also clients of other departments; effective inter-agency collaboration based on shared utilization and outcomes data is perhaps the most effective strategy to accomplish SA policy goals. However, collaboration requires funding and staff resources as well as autonomy, visibility and clout, in order to convince other State and community agencies to collaborate.

- Some respondents felt that reliance on personal leadership instead of organizational structure provided only a temporary solution to substance abuse policy imperatives when a longer term solution of structural autonomy was needed to assure effective State-funded substance abuse services.

Relationship to Mental Health Agency

- There are important differences between the substance abuse and mental health policy environments:

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- Mental health treatment is an entitlement for most individuals with severe mental illness. Departments of Mental Health aim to provide services to as many of these persons as possible because they are mandated to do so.

- In comparison, substance abuse treatment services are made available only to about twenty percent of those who are members of the substance dependent population, rather than to the entire target population.

- Substance abuse agencies and mental health agencies may be organizationally close to or distant from one another in State government. However, substance abuse spending in States is much lower than mental health spending, which generally implies that substance abuse agencies are smaller. The sources of funding for mental health and substance abuse are quite different from one another.

    - Federal funding other than Medicaid and Medicare provides 16% of the funds for substance abuse but only 4% for mental health[5]. These funds are primarily from the Federal Block Grant Programs for substance abuse and for mental health.

    - Medicaid, a joint State-Federal program, provides substantially greater support of mental health services than of substance abuse treatment services, in part due to the Federal stipulation that people who are disabled due to drug addiction or alcoholism are ineligible for Social Security Disability Income (SSDI) and Supplemental Security Income (SSI) benefits and, therefore, Medicaid coverage linked to these programs. SSDI and SSI remain important sources of support for individuals (children, adolescents and adults) with a mental health disability.

    - Substance abuse treatment services fall under the optional services that States can elect to cover or not cover under Medicaid.

    - For the nation as a whole, total State and Federal public expenditures for mental health are 5.5 times the public expenditures for substance abuse, and State expenditures for mental health are 6.2 times those of State expenditures for

[5] SAMHSA *National Expenditures for Mental Health and Substance Abuse Treatment 1997* DHHS Publication No. SMA 003499 2000

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substance abuse[6]. In comparing State spending for mental health and substance abuse, the majority goes to mental health: 86% of total State and local spending for mental health and substance abuse went for mental health in 1997.

- Respondents from States where services are provided by some entities that combine substance abuse and mental health services and others that provide specialty substance abuse treatment services only reported that combined or integrated services had the following characteristics:

    - The definition of co-occurring disorders is broadened so that a much larger proportion of substance abuse patients are diagnosed with a mental health disorder.
    - Mental health practitioners and substance abuse practitioners have different evidence-based best practices and little or no cross training. Combining services administratively does not necessarily address this issue.
    - Practitioners with a mental health background are more likely to diagnose substance abuse patients as having mental health disorders than substance abuse disorders, an observation similar to what has been amply demonstrated in the literature on primary care physicians' propensity to diagnose some mental health disorders but to miss substance abuse disorders.

- Centralizing budget and fiscal functions that were formerly within the State substance abuse agency has been a component of consolidation efforts in several States. Staff from these departments believe strongly that this centralization caused in a loss of programmatic expertise, focus and priority in the substance abuse budgetary function. The centralization resulted in a lack of ability to understand or model the policy implications of proposed changes in substance abuse budgets and finances. Substance abuse financing/reporting required under the Federal Block Grant was believed by these individuals to have been negatively affected when the functions were centralized upward.

- Clients with co-occurring mental health and substance abuse disorders benefit both from mental health and substance abuse treatment services. According to the Federal Drug and Alcohol Services Information System, only 16% of substance abuse treatment admissions in 2001 were for clients with a

[6] SAMHSA *National Expenditures for Mental Health and Substance Abuse Treatment 1997* DHHS Publication No. SMA 003499 2000

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co-occurring mental health disorder[7], which was not necessarily a serious mental illness. Although this is probably a significant underestimate, since many of the programs that are funded by the SAPT block grant and supply the data for this observation do not have mental health professionals qualified to make a diagnosis of a mental health disorder, the point remains that most people who are treated for substance abuse are not found to have a mental health disorder.

Turning to the epidemiologic perspective, 23.2% of the members of the targeted public mental health population, clients with severe mental illness (SMI), also have a substance use disorder[8]. Moreover, about 29% report use of an illicit drug in the past year. Among adults with substance dependence or abuse, 20.4% had SMI, according to the National Survey on Drug Use and Health. The great majority of SA clients do not meet the public sector criteria for SMI necessary for entitlement to State-provided mental health services.

TABLE II

PERSONS AGED 18 OR OLDER WITH SERIOUS MENTAL ILLNESS (SMI) AND SUBSTANCE USE DISORDER (SUD)
2002[9]
(Thousands)

		SUBSTANCE DEPENDENCE/ABUSE		
		YES	NO	TOTAL
SMI	YES	4,048	13,435	17,483
	NO	15,749	159,674	175,423
	TOTAL	19,797	173,109	192,906

Because the intersection of the target populations for the two conditions in the general population – those who report serious mental illness and substance dependence/abuse – is such a small proportion of the total of the two populations (12.2%), treating co-occurring disorders may be more of a programmatic and clinical issue than an organizational placement issue within

[7] SAMHSA, Office of Applied Studies, *The DASIS Report*, "Admissions with Co-occurring Disorders: 1995 and 2001" April 9, 2004
[8] Epstein J., Barker, P., Vorburger, M., & Murtha, C. (2004). *Serious mental illness and its co-occurrence with substance use disorders, 2002* (DHHS Publication No. SMA 04–3905, Analytic Series A-24). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.
[9] *ibid*

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state government. Basing a system reform or restructuring on treatment of co-occurring disorders affects only about one fifth of the SA population, while ignoring other concomitant problems of many persons with substance abuse disorders.

Regardless, it must be recognized that substance use and abuse is an important issue in the treatment of those with SMI. Not only do a significant portion of the clients in the public mental health population with SMI have a substance use disorder (SUD), but substance use by these clients, even in those without SUD, can significantly undermine behavioral stability. Moreover, the prevalence of SUD in the SMI population is higher in urban areas, higher for adolescents than for adults and may be higher among public sector clients than in the population treated elsewhere. Therefore, collaboration with the State substance abuse agency is of critical importance for State mental health agencies, whereas the State substance abuse agency perceives the mental health agency as one of many State agencies with which collaboration is needed. This disequilibrium in perspectives is a potential source of tension between the two agencies. Several substance abuse agency Directors indicated that they felt more need to collaborate with criminal justice agencies than with mental health agencies.

The significant proportion of clients of a State mental health agency who have substance use and abuse issues may imply to the mental health agency that its ability to fulfill its organizational mission would be improved if it could simply subsume the substance abuse agency into its operations so as to be able to exert greater control on behalf of its clients. However, the evidence developed to date in this nine State study clearly indicates that this submersion or merger would or actually has significantly degraded the ability of the State substance abuse agency to fulfill its mission, which requires dealing with clients from many other State agencies through extensive collaborative efforts, especially involving criminal justice, in addition to collaborating with the mental health agency.

Other Significant Policy Issues Raised by Respondents

- Political attitudes towards and sympathy or lack of support for substance abuse treatment have an importance beyond structure and leadership:
    - One strong Director in a “nested” (See definition, following) department mentioned that over the past five years there had been four individuals in positions superior to his in the Department: two

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"sympathetic" to substance abuse issues and two "not sympathetic" to substance abuse issues. The differences had an important impact on this long term Director's ability to obtain resources for key strategic initiatives to improve substance abuse treatment, despite the Director's own personal charisma and experience.

- Substance abuse policy has a fundamental relationship with Federal policy – the Substance Abuse Prevention and Treatment (SAPT) Block Grant accounts for almost half of all public SA spending in many States. In 1999 the SAPT Block Grant accounted for approximately 40% of public funds nationally expended for prevention and treatment of substance abuse. Twenty-two States reported that greater than 50% of their total funding for substance abuse prevention and treatment programs came from the Federal block grant[10]. Conversely, mental health services and policy are much more State driven because of the relatively greater importance of State funding to public sector mental health. The mental health Federal block grant is smaller than the substance abuse block grant – about 24% as large. Thus the Center for Mental Health Services Block Grant is a much smaller proportion of total State spending on mental health services than the SAPT Block Grant is on State Substance Abuse Agency spending.

- State level accountability and oversight mechanisms are a fundamental component of a well managed, effective and high quality public substance abuse prevention and treatment system. Licensing, certification and accreditation requirements alone are insufficient for this purpose. Monitoring, operating and evaluating the results of these mechanisms is a State-level function that requires sufficient agency independence, staff and other resources to accomplish successfully.

- Despite the reported need for reform and reorganization, the impact of recent and continuing structural changes within State substance abuse agencies and in State government generally may take a considerable time to evolve and for the impact, good or bad, to become apparent.

ORGANIZATIONAL PLACEMENT OF STATE SUBSTANCE ABUSE AGENCIES

The organizational placement of State substance abuse agencies is a key dimension affecting organizational performance through its impact on autonomy

10 http://www.samhsa.gov/funding/funding.html

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and influence. Autonomy, whether achieved through structure or leadership, substantially determines the capacity of a State substance abuse agency to develop and implement policy initiatives that are responsive to the needs of its own vulnerable clients and inter-agency stakeholders. One of the most important determinants of autonomy, and one that is highly correlated with organizational placement, is whether or not the SSA Director is appointed by the Governor. Appointment of the State agency Director by the Governor confers authority, credibility and status, as well as indicating the priority of substance abuse issues within State government. Organizational placement of the State substance abuse agency within a State government structure affects the influence and thus the ability of an agency to promote and actually implement policy initiatives through the power conferred by a close relationship to the Governor's office. Influence may be achieved through a variety of mechanisms, some direct and some subtle, but advantageous organizational placement is the fundamental predisposing requirement. The following State classification matrix illustrates the four key types of placement found in the nine States included in this study to date:

TABLE III

STATE CLASSIFICATION MATRIX

STATES WITH HIGH AUTONOMY SUBSTANCE ABUSE AGENCIES	STATES WITH MERGED SUBSTANCE ABUSE AND MENTAL HEALTH AGENCIES	STATES WITH NESTED SUBSTANCE ABUSE AGENCIES SEPARATE FROM A BEHAVIORAL HEALTH AGENCY	STATES WITH NESTED SUBSTANCE ABUSE AGENCIES WITHIN A BEHAVIORAL HEALTH AGENCY
New York		Massachusetts	Georgia
Florida	North Carolina	Washington	Michigan
Ohio		California	Texas

Notes on Classifications:

- Florida: Dual appointment of SSA in cabinet-level office of "Drug Czar" provides autonomy despite SSA being component of Child and Family Services agency.
- Massachusetts: Substance abuse agency is organizationally lower level than mental health agency; this is not true in Washington State
- Michigan SSA combines Office of Drug Control Policy ("Drug Czar") with substance abuse agency

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States in this study with "high autonomy" substance abuse agencies had agencies with a close formal organizational relationship to the Governor and two were cabinet level agencies (Ohio and New York). States with a substance abuse agency fully merged (rather than nested as an independent entity) with a mental health agency have the potential for having the least autonomy of any of the placement models examined here. States with "nested" substance abuse agencies have the substance abuse agency reporting to a larger organization (generally Health Services or DHHS) and are thus at least one organizational level removed from the Governor. The number of organizational levels between the SSA and the Governor is an indicator of the degree of submersion of an SSA.

KEY FINDINGS FROM STATE INTERVIEWS

FLORIDA

- The Director of the State substance abuse agency (SSA) is also the Deputy Director for Treatment of the Florida Office of Drug Control (ODC), a cabinet-level agency with close ties to the Governor. This position in the cabinet-level office that also has a close relationship to the Governor has facilitated recent promotion of a strong substance abuse policy agenda in the State. This occurs despite the fact that the SSA remains formally within the Child and Family Services Agency.
- The SSA has recently been elevated in organizational status to a level equal to mental health, rather than reporting to it, as it did formerly.
- Separation of the SSA from the Department of Mental Health in 1997 significantly enhanced the visibility and ability of the Director of Substance Abuse to advance key SA policy objectives in concert with ODC, in the opinions of the SSA Director and the Director of Mental Health. Substance abuse providers had been very disturbed about the SSA's lack of influence and resources when it was reporting to mental health in the Department of Children and Families. The State's mental health Director, the person to whom the SSA formerly reported, strongly concurred with the opinion of the SSA Director on this point.

GEORGIA

- The functions of the Office of Substance Abuse have been almost completely regionalized and decentralized and the Office is now within the Division of Mental Health, Developmental Disabilities and Addictive Diseases, within the

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Department of Human Resources. The Office of Substance Abuse has a Chief and three staff; the (Acting) State Methadone Authority (SMA) officer is a physician at a regional psychiatric hospital, not an SA agency staff member.

- Lack of agency personnel at the State level and subordination within DMHDDAD have made engagement in collaborative efforts with other entities and agencies very challenging, if not impossible, for the Georgia State agency.
- As another consequence of limited staffing, State-level accountability mechanisms or oversight of substance abuse treatment services are minimal as is the ability of the SSA to track outcomes and produce reports needed by Federal or other agencies and funders.
- The current public SA treatment system is highly responsive to local and regional provider needs and demands, rather than to those of consumers and other stakeholders because State-level resources are lacking.
- The Director and his three staff find it difficult to be collaborative and fully responsive to Federal and State requirements

MASSACHUSETTS

- The SSA in Massachusetts is a Bureau led by an Assistant Commissioner within the Department of Public Health, within the Office of Health Services, within the Executive Office of Health and Human Services.
- Placement of the SSA within the Department of Public Health has meant that a strong public health emphasis and focus on prevention has developed but that other substance abuse emphases and priorities are not equally prominent.
- The fact that the Department of Mental Health is headed by a Commissioner and the Bureau of Substance Abuse Services is headed by an Assistant Commissioner means that the two agency heads never meet with one another; all inter-agency collaboration between these two agencies reportedly occurs at a staff level only.
- The SSA has issue-dependent but rare direct access to the Governor's office in matters of public health concern but no direct access to the legislature; all budget and fiscal matters are handled by the Department of Public Health.
- Massachusetts is facing threatened reductions in Federal block grant funds because of failure to meet maintenance of effort (MOE) requirements due to years of reductions in State substance abuse expenditures.

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MICHIGAN

- The Division of Substance Abuse and Gambling Services was merged with the Michigan Office of Drug Control Policy in 2003. The merged functions provide a newly visible platform for the promotion of substance abuse policy initiatives.
- The newly merged office is within the Bureau of Mental Health and Substance Abuse, within the Department of Community Health.
- The merger has increased the scope of responsibilities and reportedly facilitated collaboration with multiple State and community entities.
- The Director has used the new visibility of the combined position to make informal but visible personal connections with the Governor's Office and the Legislature, in order to develop and enhance relationships that are otherwise managed through the Department of Community Health.
- SA budget and fiscal matters are still managed by the Department of Community Health.
- MH and SA Directors and staff are housed in close physical proximity and have many formal collaborative efforts ongoing, as well as frequent informal meetings and conversations.

NEW YORK

- The Office of Alcohol and Substance Abuse Services (OASAS) in New York is one of four States in 2004 with a cabinet-level SSA.
- New York State replaced a "super-agency" form of organization of State government. Three independent agencies now exist, each of which has an appointed Commissioner: OASAS, the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities. Merger of OASAS with other agencies was considered in the past, but was rejected after analysis as being "short-sighted" and "disadvantageous" to the OASAS mission, providers, interagency needs, Federal requirements and client populations. At the time, there was serious concern expressed by the agency, providers, legislators and State officials the agency's mission would suffer if OASAS were subsumed under any other agency, including OMH, the NYS Health Department or any other State department that had another mission other than SA. The agency's unique mission and populations, including renewed emphasis on the use of data and information systems for management, its commitment to specialized best practices and prevention, its need to have an independent policy voice and to meet Federal reporting requirements and

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MOE were felt to be too unique and important to allow OASAS to be subsumed in or merged with another agency.

- The agency maintains a variety of data systems, including a Prevention Risk Indicators Monitoring System and a service need and utilization data system, which is designed to allow examination of client behaviors during a specific time period prior to admission and during a corresponding period prior to discharge. This latter system can be used to assess behavioral change during treatment and at discharge.

- These unique data and information systems are one core strength of OASAS and a foundation of its strategy to demonstrate the continuing positive impact of its services to its multiple stakeholders, including local, State and Federal governments.

- OASAS emphasizes the importance of inter-agency collaboration. Leaders of OASAS believe that their position as an independent, cabinet-level agency facilitates entrée and continuing collaboration with other State entities and the Governor's office.

NORTH CAROLINA

- SA, MH and DD were combined at the State and community levels in North Carolina in an ongoing statewide "mental health reform" that includes substance abuse. This reform has conceptualized the new Agency as having two divisions: inpatient treatment and community policy/treatment.

- The North Carolina Chief of Community Policy Management, who was formerly the State Director for Substance Abuse, is now the official Single State Agency (SSA) Executive both for substance abuse and for mental health. There is not a separate State substance abuse office in the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services but there are dedicated substance abuse-specific staff members.

- The Department head, who is appointed by the Governor and has served both in Republican and Democratic administrations, has an extremely close and longstanding relationship with the Departments of Corrections and Juvenile Justice on substance abuse issues.

- Development of an effective State data infrastructure over the past ten years has facilitated mental health reform and substance abuse system reform by providing information allowing modeling the financial impacts of this reform

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and permitting the new mechanisms of contracting and payment that are the heart of this reform. This accomplishment was made possible by some continuity at the top in the key leadership positions during this period.

- The Chief of Community Policy Management is a gubernatorial appointee who has strong independent relationships with the Governor's Office and legislators to help promote substance abuse and other policy initiatives. She chaired the design committee of the reform initiative.

- The Chief of Community Policy Management is a nationally recognized substance abuse policy expert and the former State substance abuse Director, so that the visibility of substance abuse policy has been able to be maintained despite the lack of a specifically designated substance abuse policy office. Additionally, the Governor's wife is a noted alcohol treatment advocate who has worked closely with the substance abuse agency.

OHIO

- The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) is an autonomous cabinet-level agency, one of four States with a cabinet-level substance abuse agency in 2004.

- The executive team at ODADAS considers Cabinet-level status crucial for the launch and success of its numerous intra-governmental collaborative initiatives, for which there are otherwise competing priorities.

- ODADAS contracts with 43 combined Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards and 7 specialty Alcohol and Drug Addiction Services (ADAS) Boards in more urbanized areas to deliver prevention and treatment services specifically for substance abuse.

- ODADAS perceives that the 7 ADAS Boards that work specifically on substance abuse services have a much greater focus on substance abuse services than do the 43 ADAMHS boards that combine the delivery of both substance abuse and mental health services.

TEXAS

- Following a recent reorganization of State government in Texas, the former Director of Substance Abuse was designated in May 2004 as the new Deputy Commissioner for Behavioral and Community Health for the Department of State Health Services (DSHS), to take office in September 2004. The impact

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of this organizational change on substance abuse agency performance, services and policy will only become evident over time.

- The impetus for this reorganization was change in the political composition of the Texas State Legislature and the election of a new Governor; the substance abuse agency has been greatly affected by the reorganization, along with the rest of the State government, but SA issues were not a cause of the reorganization.

- The ability of SA to maintain independent policymaking initiatives and meet Federal requirements now rests with the individual who will have integrated mental health and substance abuse authority, and with the two separate mental health and substance abuse offices that report to that individual.

WASHINGTON STATE

- The Division of Alcohol and Substance Abuse (DASA) is within the Health and Rehabilitative Services Administration, within the Department of Social and Health Services.

- Data and information systems and exceptionally long term executive team cohesion are the core strengths of DASA and data and reporting are the foundation of its strategy to demonstrate the impact, credibility and accountability of substance abuse services.

- Ongoing cost offset studies produced by DASA have been a key strategy to document the effect of substance abuse treatment in Washington. Such cost offsets are related to decreased cost of crime, utilization of acute health care and psychiatric services, and reliance on public assistance[11].

- Collaboration with other entities is the most important tactic used by DASA to accomplish its strategic objectives. Staff is encouraged to collaborate with other public and private entities and is allocated significant time to do so. The expectation is that effective collaboration requires the assumption of increased workload by DASA staff.

- Stability of the executive leadership group within DASA and the strength of DASA data systems have facilitated forging and maintaining positive relationships with the Governor's Office and Legislature.

[11] See, for example, SAMHSA, TAP 25: The Impact of Substance Abuse Treatment on Employment Outcomes Among AFDC Clients in Washington State

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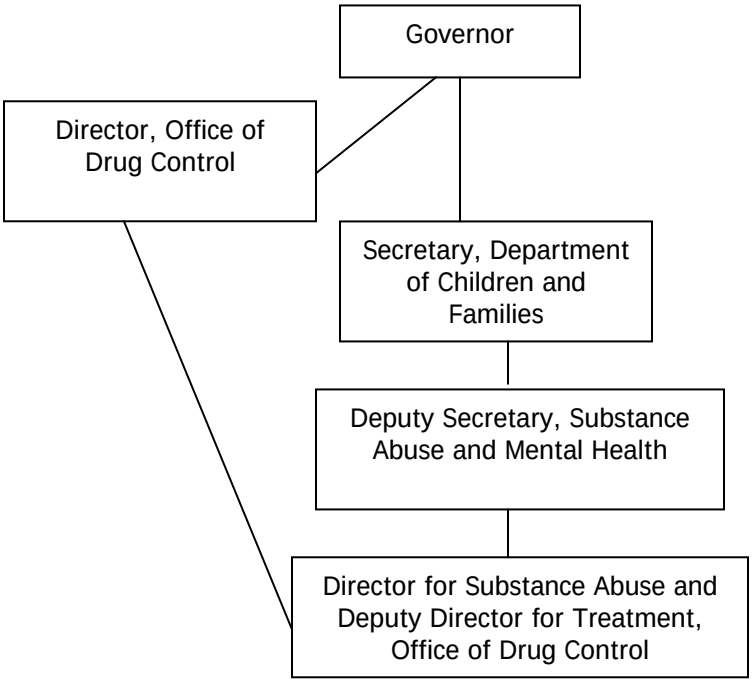
SPECIFIC STATE INFORMATION

FLORIDA

Organizational Placement of AOD Agency



Organization of Office of Substance Abuse

- State Director for Substance Abuse is also Deputy Director for Treatment of the Office of Drug Control (ODC).
- Office of Drug Control established by Governor and now incorporated into Florida statute; Florida has a “drug czar” appointed by the Governor; he previously worked at the Federal Office of National Drug Control Policy (ONDCP).
- ODC has direct access to Governor; SA obtains access via ODC and Secretary of Department of Children and Families.

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- ODC has raised issues of substance abuse policy to the forefront in Florida. ODC convenes an annual statewide Drug Control Summit hosted by Governor in which the SA agency participates.

- A new non-profit behavioral health corporation, the Florida Substance Abuse and Mental Health Corporation, was created in 2003 to provide external oversight both of the mental health and of the substance abuse systems, and to make policy and resource recommendations to improve coordination, quality and efficiency (bill signed by the Governor 7/11/2003). Members of the corporation had only met twice as of 5/2004; the position of Executive Director was unfilled at that time.

- **History of Florida Substance Abuse Agency: Separation from Mental Health**

  - In the mid 1990's, providers and consumers, dissatisfied with access to and management of substance abuse services, demanded reform and focus on substance abuse treatment services at the State level.

  - In the fall of 1997, substance abuse was split from mental health, to which it had reported, to elevate it to a separate Office within the Department of Children and Families (DCF). This change reportedly enhanced the ability of Director of Substance Abuse to advance key SA policy objectives. The Director stated that "more has been accomplished in five years after separation from MH than in the ten years prior to separation" due to increased ability to convey substance abuse policy priorities to State policy leadership.

  - The Florida Office of Drug Control was established in 1999. The Director is appointed by Governor.

  - Since 2001, the Director of Substance Abuse has had a dual appointment as ODC Deputy Director for Treatment.

  - The Director of Substance Abuse feels that the separation from mental health and the link with the ODC facilitated a unique focus on substance abuse issues. Prior to separation and ODC, the top three to four priorities of the combined substance abuse and mental health department were always exclusively mental health issues. Any upward or outward communication of departmental priorities showed that the top 3-4 out of top five were mental health related. Now, <u>two</u> Directors (MH and SA) are always at the

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table and mental health and substance abuse issues are discussed together and with equal emphasis.

Organization of Services

- Local programs, as opposed to the State agency, tend to have both mental health and substance abuse services, but they are not necessarily integrated.
- Key State-level mental health and substance abuse functions have been separate since 1997.
- Mental health and substance abuse do combine certain functions at the State level:
  - Data System
  - Planning
  - Contracting with Providers
  - TANF-related Programs

Data and Information

- Mental health and substance abuse have their own shared data system within DCF. This independence from other DCF systems has permitted focus on needs of substance abuse, which otherwise risked being accorded secondary status in terms of IT priorities. The Director believes that a strong, independent information system has been critical to the success of Division of Substance Abuse. This belief is seconded by the MH Director who had supervised SA in its prior organizational placement under mental health.

Access to Office of Governor and Legislature

- Departmental re-organization in 2003 transferred SA budget position from DCF Commissioner's Office to Substance Abuse Agency. This provides direct line authority over the SA budget, a

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key measure of the amount of control over agency priorities and operations that can be exercised by the Director. DCF still exercises decision making authority over the SA budget, but the Substance Abuse Agency has increased authority over the preparation and ongoing management of its budget. This provides for substantially greater autonomy.

- Appointment of the Director of Substance Abuse to ODC provides augmented access to legislative appropriations committees.

- The strong relationship with ODC also provides access to the Governor's Office, an important measure of the amount of influence the Director of SA is able to exercise in order to achieve SA policy initiatives and priorities.

State Data from SAMHSA

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION	2001 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE **	2001 ILLICIT DRUG TREATMENT GAP **	2002 PER 1000 SA TREATMENT ADMISSIONS *	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT $	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	$7.04	6.97	2.02	8.1	1.15	1.16
FLORIDA	$6.83	6.54	1.69	6.3	0.92	0.96

* SAMHSA, Substance Abuse Treatment Admissions by State, 2002

** SAMHSA (OAS) State Estimates of Substance Abuse From the 2001 National Household Survey on Drug Abuse

- Florida receives slightly less per-capita from the SAPT block grant than the US average (2003).

- The rate of alcohol or illicit drug dependence or abuse in Florida is slightly less than the US average (2001).

- The rate of admissions to substance abuse treatment in Florida is about 20% less than the US average (2002). Nevertheless, the SAMHSA-defined illicit drug treatment gap is 16% below the national average.

Florida Budget and Expenditure Data

- Information obtained from Florida indicates a $277 million to $295 million or 6.4% increase in substance abuse funding from the 2003/2004 budget year

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to the 2004/2005 budget year. The 2004/2005 budget includes $258 million for prevention and treatment and $37 million for law enforcement, prosecution and other services related to substance abuse in the criminal justice system. This is a substantially greater increase than the 2.6% increase in the entire Florida State expenditure budget. Funding from Florida general revenues increased substantially in the 2004/2005 budget year.

- Public funding for substance abuse prevention and treatment in Florida has increased in every year but one since the 1998/1999 budget year. In the 2001/2002 budget year, funding decreased by 1%, a decrease that was reversed by a 4% increase in the following year.

- Funding for substance abuse prevention and treatment in Florida is $18.53 per capita in 2004/2005.

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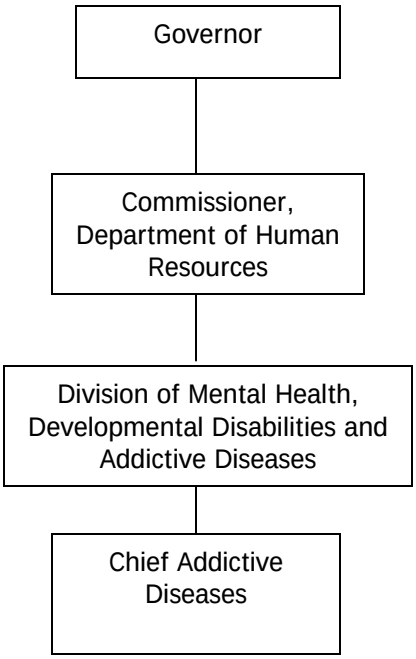
GEORGIA

Organizational Placement of AOD Agency



Organization of Office of Substance Abuse

- The Division of MHDDAD is one of seven divisions within Georgia's Department of Human Resources.
- The Office of Substance Abuse has Chief of Addictive Diseases and three staff.
- The State Methadone Authority (SMA) is currently a physician at a regional public psychiatric hospital, not a substance abuse physician.
- There is no separate budget, fiscal or planning functions for substance abuse; all are centralized and report directly to the Division Director and then to Commissioner of Human Resources.

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Organization of Services

- Many of the Division's functions were decentralized to regional boards in 1993. Each regional board is responsible for MH, SA and DD. Regional boards hold all SA/MH provider contracts themselves.
- The number of regional boards was consolidated to seven in 2003.
- Medicaid funds some substance abuse services through TANF; a relatively comprehensive set of services is available through Medicaid for this largely female population.

Impact of Nested State-Level Substance Abuse Function in Division of MH/SA/DD

- Relative to other States, there is limited State SA staffing (four positions) for a State of Georgia's size, limited State-level substance abuse oversight of substance abuse treatment services, limited possibilities for collaboration with other agencies at State level or for State level SA system accountability.
- There is limited visibility or possibility for State substance abuse policymaking. The State is heavily dependent on regional MH/DD/SA boards and State-level SA reporting is diffuse and difficult.
- The addictions chief believes that the very small staff size in the Office of Substance Abuse prevents more effective collaboration with other State and Federal agencies and departments due to personnel/resource constraints.
- The Atlanta Journal-Constitution (9/14/03) reported that at almost any time in the past decade, one or more of the State's regional boards have been under some kind of criminal, financial or administrative review. Limited State oversight was reported to have been a significant source of these problems.
- The substance abuse treatment system is highly responsive to regional and provider needs and demands, rather than to State oversight, because State-level resources are so limited.

Access to Office of Governor and Legislature

- The AOD budget is controlled by the Office of Planning and Budget Services in DHR, not by Addictions unit.

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- The AOD Director never meets with Governor of Governor's Office staff.
- The AOD Director meets with legislators only by special request, once every two years or so. The Director did not meet with any legislators during the last session.

State Data from SAMHSA

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION	2001 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE **	2001 ILLICIT DRUG TREATMENT GAP **	2002 PER 1000 SA TREATMENT ADMISSIONS *	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT $	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	$7.04	6.97	2.02	8.1	1.15	1.16
GEORGIA	$6.97	6.01	1.77	5.0	0.72	0.84

* SAMHSA, Substance Abuse Treatment Admissions by State, 2002

** SAMHSA (OAS) State Estimates of Substance Abuse From the 2001 National Household Survey on Drug Abuse

- Georgia receives very slightly less per capita from the SAPT block grant than the US average (2003).
- The rate of alcohol or illicit drug dependence or abuse in Georgia is 14% less than the US average (2001).
- The rate of admissions to substance abuse treatment in Georgia is 38% less than the US average (2002). Nevertheless, the SAMHSA-defined illicit drug treatment gap is 12% below the national average.

Georgia Budget and Expenditure Data

- Information obtained from Georgia indicated a 17% increase in State-funded substance abuse services from State fiscal year 2000 to State fiscal year 2001. This was followed by a 1% decline for State fiscal year 2002, a period that also saw an increase in Federal funds that more than offset the decline in State funds.
- Total funds for substance abuse prevention and treatment services in State Fiscal year 2002 were $91.7 million, or $13.46 per capita.

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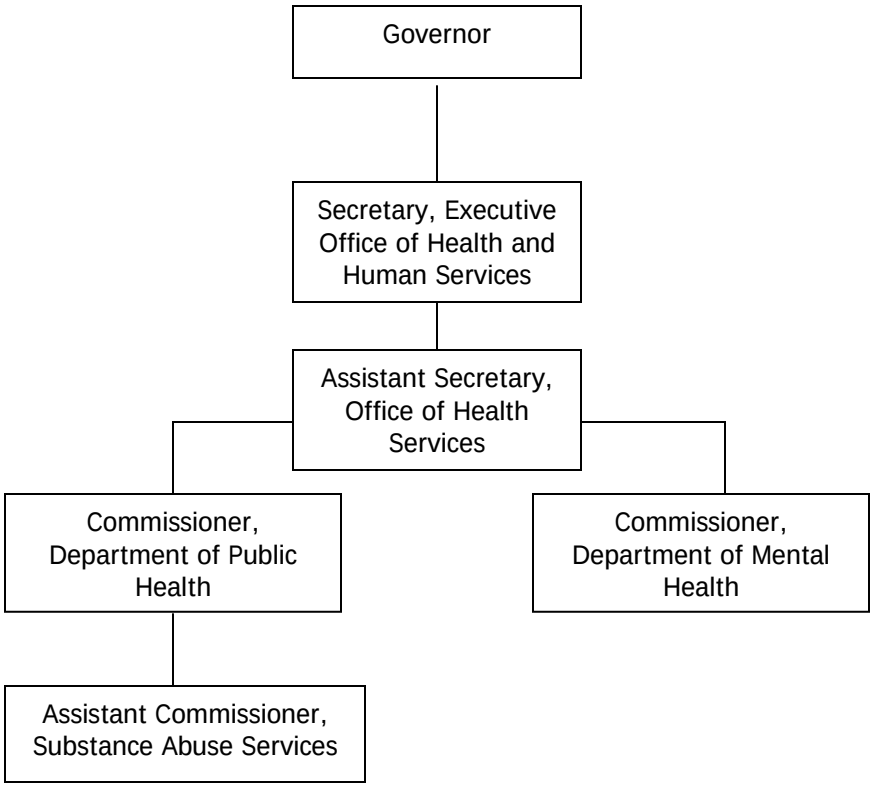
MASSACHUSETTS

Organizational Placement of AOD Agency



Organization of Services

- A major State government reorganization occurred in July 2003, following election of a new Governor. Seventeen separate agencies within the Executive Office of Health and Human Services (EOHHS) were grouped into five offices, one of which is the Office of Health

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Services. The Office of Health Services has four Departments or Divisions:

- Medicaid
- Department of Public Health
- Department of Mental Health
- Division of Health Care Finance and Policy

Impact of Reorganization on Bureau of Substance Abuse Services

- Direct SA access to legislature is blocked; all contact with legislature is coordinated through EOHHS only.

- Budget and fiscal responsibility shifted from the Bureau of Substance Abuse to the Department of Public Health. Budget and fiscal staff is no longer easily available to model precise SA-specific programmatic and policy impact of proposed changes in the substance abuse budget or fiscal policy.

Relationship of Substance Abuse Services to Department of Mental Health

- The Directors are at different levels; Mental Health is headed by a Commissioner and Substance Abuse is headed by an Assistant Commissioner.

- Mental Health has its own budget line; Substance Abuse is one of many functions within the Department of Public Health and does not have its own budget line.

- The Director of Substance Abuse does not meet with the Commissioner of Mental Health; all contact is at the staff level; collaboration exists, but substantial budget cuts over past three years have reduced the ability of SA to collaborate.

- Massachusetts has mental health parity but not substance abuse parity. Mental health parity in Massachusetts requires that State-regulated health insurance plans (primarily plans provided by small employers that are not regulated under ERISA) and plans for State and local employees to provide mental health benefits for certain mental

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disorders at the same level of coverage provided for other health conditions.

Core Strategic Initiative: Prevention

- Placement of Bureau of Substance Abuse in Department of Public Health has meant that the Bureau has a strong prevention function. The focus of the Bureau is currently on prevention.

Collaboration with other Entities

- The focus of collaborative efforts with other agencies within Department of Public Health has a public health focus, including:
  - HIV / AIDS;
  - Hepatitis C;
  - Domestic Violence; and
  - Homelessness.
- Other important collaborative efforts include the
  - Department of Mental Health;
  - Department of Transitional Assistance;
  - Department of Social Services;
  - Department of Mental Retardation;
  - Executive of Public Safety, including Department of Corrections;
  - Deaf and Hard of Hearing;
  - County Houses of Corrections; and
  - Tobacco Control Program.

Access to Office of Governor and Legislature

- The Assistant Commissioner for Substance Abuse met with the Governor and governor's staff a dozen or so times this year because of the sudden emergence of substance abuse budget issues and publicity concerning public safety issues related to substance abuse. This was unusual; similar meetings have not occurred in previous years.

- The Assistant commissioner for substance abuse has no meetings with legislators

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Relationships to Providers

- Introduction of managed care through the Massachusetts Behavioral Health Partnership was the impetus for merging the substance abuse provider and mental health provider trade associations.
- The combined association has focused primarily on mental health issues and has not achieved consensus on substance abuse issues – a gap remains among specialty substance abuse providers, those with a substance abuse focus, and multi-service providers whose focus is on mental health and other services.
- Residential substance abuse treatment providers have their own trade association.
- The Bureau of Substance Abuse licenses all providers of substance abuse treatment services and contracts with providers for services to publicly funded clients.

State Data from SAMHSA

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION	2001 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE **	2001 ILLICIT DRUG TREATMENT GAP **	2002 PER 1000 SA TREATMENT ADMISSIONS *	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT $	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	$7.04	6.97	2.02	8.1	1.15	1.16
MASSACHUSETTS	$6.47	9.13	2.54	12.8	1.98	1.40

* SAMHSA, Substance Abuse Treatment Admissions by State, 2002

** SAMHSA (OAS) State Estimates of Substance Abuse From the 2001 National Household Survey on Drug Abuse

- Massachusetts receives 8% less per-capita from the SAPT block grant than the US average (2003).
- The rate of alcohol or illicit drug dependence or abuse in Massachusetts is 31% higher than the US average (2001).
- The rate of admissions to substance abuse treatment in Massachusetts is 58% higher than the US average (2002). Nevertheless, the SAMHSA-defined illicit drug treatment gap is 25% above the national average.

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Massachusetts Budget and Expenditure Data

- Information obtained from Massachusetts indicates that total appropriations for substance abuse have declined each year since budget fiscal year 2001, and in 2004 were 21% below the level in 2001.
- Massachusetts is facing threatened reductions in Federal block grant funds because of failure to meet SAPTBG maintenance of effort (MOE) requirements due to reductions in State substance abuse spending.
- Total appropriations for substance abuse prevention and treatment services in budget fiscal year 2004 was $33.2 million, or $6.29 per capita.

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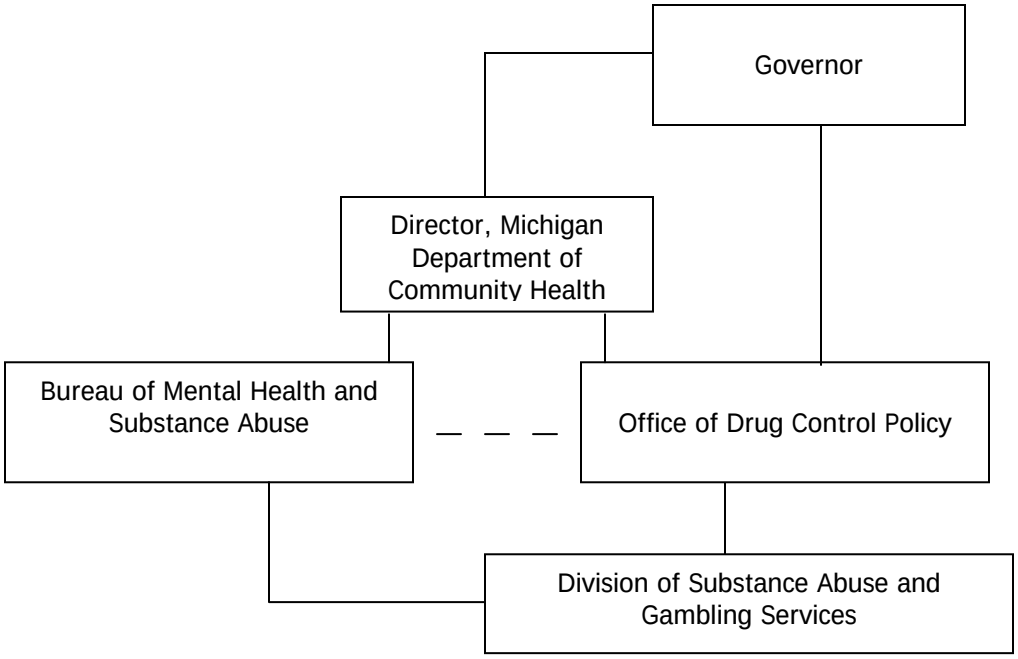
MICHIGAN

Organizational Placement of AOD Agency



Organization of Office of Drug Control Policy and Division of Substance Abuse and Gambling Services

- In 2003, the Division of Substance Abuse and Gambling Services (DSAGS) was merged with the Office of Drug Control Policy (ODCP) and a "Drug Czar" was appointed by the new Governor to lead the merged functions.
- The position of Director of ODCP provides a newly visible platform for promotion of substance abuse policy priorities, concerning both prevention and treatment.
- The goal of ODCP/SA merger was to eliminate fragmentation between law enforcement and the treatment and prevention of substance abuse. There was a lack of coordination and collaboration between the police/law enforcement agencies and the substance abuse agency.

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- The impetus for the merger came from newly appointed Director, who wanted to increase the scope and effectiveness of the position of Director of ODCP in order to improve substance abuse education, prevention, treatment and enforcement.

- The Office of Drug Control Policy has been in existence since 1991, and was transferred to the Department of Community Health in 1996.

Organization of Services

- The recently restructured ODCP has four principal functions, including:
    - Prevention;
    - Education;
        - Safe and Drug-Free Schools and Communities
    - Law Enforcement; and
        - Byrne Memorial Formula Grants
        - Local Law Enforcement Block Grants
        - Drug Courts
    - Treatment.

- The ODCP contracts with Regional Coordinating Agencies for SA services are now managed by ODCP and the Division as part of the reorganization, instead of by the Bureau of Community Mental Health Services. This change was significant and "fundamental to achieving policy goals" by enhancing the ability to increase the accountability of Regional Coordinating Agencies and, through them, the SA service providers.

- Other funds flowing through the agency include:
    - The SAPT Block Grant;
    - Byrne Grant Program Funds;
    - Local law Enforcement Block Grant Funds; and
    - The Safe and Drug Free Schools and Communities Funds.

- Substance abuse treatment services are provided through the 16 Regional coordinating Agencies, which directly hold all substance abuse provider contracts. The regional coordinating Agencies may be components of local health departments, integrated MHSA entities, or components of 501c3 agencies. Services are provided by a large variety of entities, including specialty substance abuse providers and multi-service agencies.

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- The merger of ODCP with DSAGS has facilitated collaboration between substance abuse treatment/ prevention/education and criminal justice/law enforcement.
    - An effort is under way to shift the provision of substance abuse treatment to parolees from direct contracts between service providers and the Department of Parole to the Regional Coordinating Agencies.
    - There are 63 drug courts in various stages of implementation, from planning to fully operational.

Relationship to Mental Health

- MH and SA both attend regular monthly DCH senior staff meetings.
- The MH and SA Directors are in close physical proximity and have informal conversations daily. The staff of the divisions are in similarly close physical proximity, which facilitates collaboration.
- MH and SA jointly conduct coordinated quality assurance site visits.
- Mental Health – Substance Abuse management team is active with twice monthly formal meetings and additional joint projects and meetings.
- Current collaborative efforts focus on various topics, including:
    - Co-occurring disorders;
    - MHSA managed care; and
    - Best Practice Initiative(s).

Access to Office of Governor and Legislature

- All formal relationships with the Governor and Legislature are managed through the DCH liaison office; the ODCP Director has informal contacts with both.
- The Budget function is centralized in the DCF office of Budget and Finance.
- The combination of the ODCP and the Bureau of Substance Abuse under the same Director has created a highly visible position in State government, even though the Director is formally within the Bureau of Mental Health and Substance Abuse, within the Department of Community Health. The Director has taken the opportunity provided by this visibility to meet directly with

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legislators, the Governor, and the Governor's staff regularly in order to promote substance abuse policy and prevention initiatives, such as changing to a prevalence-based formula for resource allocation, increasing standards of accountability, and increasing the number of drug courts.

- The increased visibility has permitted the new Director to communicate to State policymakers about the consequences of failing to meet MOE requirements and the impact of such a failure on the SAPT Block Grant, and the funding of local treatment and prevention programs.

State Data from SAMHSA

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION	2001 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE **	2001 ILLICIT DRUG TREATMENT GAP **	2002 PER 1000 SA TREATMENT ADMISSIONS *	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT $	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	$7.04	6.97	2.02	8.1	1.15	1.16
MICHIGAN	$7.15	7.14	1.99	7.8	1.09	1.10

* SAMHSA, Substance Abuse Treatment Admissions by State, 2002

** SAMHSA (OAS) State Estimates of Substance Abuse From the 2001 National Household Survey on Drug Abuse

- Michigan receives slightly more per capita from the SAPT block grant than the US average (2003).

- The rate of alcohol or illicit drug dependence or abuse in Michigan is slightly greater than the US average (2001).

- The rate of admissions to substance abuse treatment in Michigan is slightly less than the US average (2002). The SAMHSA-defined illicit drug treatment gap is very slightly less than the national average.

Michigan Budget and Expenditure Data

- Total spending for substance abuse prevention and treatment remained essentially constant from State fiscal year 2000 to 2002. However, the components changed slightly, with Medicaid funds increasing by 18% and non-Medicaid State funds decreasing by 6%.

- Total spending for substance abuse prevention and treatment was $111.9 million in State fiscal year 2002, or $13.76 per capita. This figure includes Medicaid spending for substance abuse treatment.

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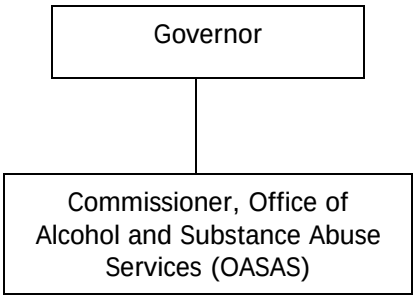
NEW YORK

Organizational Placement of the AOD Agency: Autonomous, Cabinet Level Agency



Organization of Services

- OASAS has a Cabinet-level Commissioner and a 5-person Executive Team, reporting to the Commissioner, that helps manage the agency; the team includes one Executive Deputy Commissioner and four Associate Commissioners, one each for Administration, Treatment, Prevention and Quality/Standards.

- The current OASAS' structure differs from that of the 1978 model of having two divisions, one for alcohol and one for substance abuse, a typical structure at that time in many States. The two divisions, the Office of Mental Retardation and Development Disabilities (OMRDD) and the Office of Mental Health (OMH) were once part of the State's Department of Mental Hygiene.

- In 1992, the two SA divisions were consolidated into OASAS. It took several years for the State OASAS agency to fully integrate alcohol and other drug functions. For example, the regulations for integrating the reimbursement rates for alcohol and other drug treatment were not completed until 2004.

- There are still some remnants of this older dual alcohol/drug approach in the State. For example, some of the remaining staff remember and worked with the two different cultures. The alcohol treatment culture was more medically oriented than the substance abuse culture and also had a well-developed outpatient halfway house, supportive living and brief treatment model In contrast, the drug abuse treatment

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culture initially tended to favor the "resocialization" model that was characterized by longer-term residential treatment centers (these centers have now become much shorter term because of the influence of managed care).

- Consolidated teams and processes in OASAS were in place within 6-8 years after consolidation was announced; however, the consolidation of the separate alcohol and drug treatment systems took more than 10 years.

- The need for focused prevention services; the large population of New York State heroin abusers being treated with methadone; the large number of other illegal drug users and drug activities such as methamphetamine labs, homeless and addicted persons; the many addicted individuals with HIV/HepC and AIDS; and the widespread and enduring stigma attached to addiction have helped OASAS maintain its separate identity and priority within State government.

  The agency's very particular mission, operating style and populations, including its emphasis on the use of data and information systems for management, its commitment to specialized best practices and prevention, its need to have an independent policy voice, and to meet Federal reporting requirements and MOE have also been instrumental in maintaining a separate identity.

- Three independent agencies (OASAS, OMH and OMRDD) replaced the former "super-agency" with 19 separate units that once comprised the NY State Department of Mental Hygiene. Each of the three agencies today, including OASAS, is called an "Office" and has a Commissioner appointed by the Governor.

- OASAS was left untouched and was deliberately not merged with mental health or any other entity during the wave of numerous New York State agency mergers that took place in '95-'96.

- New York State's current OASAS Commissioner has been in the human services and addictions field for 35 years and was appointed by the Governor. He holds a Ph.D. in pastoral psychology and other advanced degrees; he served as the Director of an Addictive Diseases Unit of the VA and in many other functions during his 35-year professional career. He was appointed in 2003, after OASAS had an Acting Commissioner for 6 months.

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- An Executive Deputy Commissioner who is an attorney and who served in the Governor's office for 7 years, as well as four Associate Commissioners, manage OASAS today. Key executive staff, other than the Commissioner, have been in place for a number of years and have worked together as a team that now includes the Commissioner and his Executive Deputy.

- In 2003, OASAS embarked on a thorough internal agency restructuring and cultural change initiative after the new Commissioner was appointed. The restructuring has been managed entirely by the Executive Deputy Commissioner and the four Associate Commissioners. OASAS' goals were to achieve leaner staffing, streamlining of agency processes, and enhanced fiscal efficiencies.

- The internal OASAS reorganization took a period of months, and was completed in October 2003. Reorganization was planned and achieved using internal staff, rather than outside consultants. OASAS' Executive Team and key staff analyzed the agency and managed the reorganization effort, which involved considerable staff movement and workflow improvement engineering.

- A major outcome of the internal reorganization was the creation of four divisions: a new Division of Prevention, signaling augmented emphasis on prevention efforts, an Administration Division, a Treatment Division, and a Quality and Standards Assurance Division.

- The reorganization consolidated fragmented capital programs, elevated prevention to a divisional structure equivalent to treatment, expanded the Division of Administration, and emphasized quality improvement, evidence-based practices, a sophisticated data infrastructure via a data warehouse, and explicit performance management indicators.

- The management team at OASAS created a "corporate" structure with the Commissioner establishing overall policy and agency philosophy that sets an overall tone and direction, which is operationalized by the Associates and their respective divisions. Operating in this way makes it clear that those in leadership are as responsible for effective functioning as are the Associates and their divisions.

- OASAS does not have final approval on its own budget, which is subject to Budget Office and legislative review. However, the OASAS Administration group is headed by an Associate Commissioner, with many years of experience, who came to OASAS from the Governor's Budget Office.

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Core Strategic Initiative: Data and Information, Collaboration and Financial Strategy

- Data and information systems are a core strength of OASAS and a foundation of its strategy to demonstrate the continuing positive impact of its services.
- Inter-agency collaboration is emphasized and strongly supported by the Governor, the Commissioner, and the Executive Team.
- OASAS participates as an autonomous agency in the Executive Budget process, one of the first such gubernatorial efforts in the U.S., and one which involves in-depth collaboration with the Budget Division. The Governor delivers a proposed budget to the Legislature for its consideration and modification, although it is reportedly easier to cut than to add to the budget in these financially constrained times.

Most Significant Policy / Organizational Change in Previous Three Years

- See internal reorganization notes above.
- The former Program Operations group was separated into treatment and prevention divisions. In this process, prevention moved from bureau to division status.
- Prevention, Quality and Standards and Treatment have recently become the key divisions, along with Administration. Prevention went from bureau to division status in the reorganization. The former Program Operations group was separated into treatment and prevention operations and assigned to the two new Divisions noted above.
- The impact of OASAS' reorganization on substance abuse treatment funding and providers is perceived by the Executive Team to have been generally positive, leaving providers with a clearer sense of how the agency operates and whom to contact for what, as well as with an enriched set of inter-agency relationships.
- As part of the reorganization and its new priorities, OASAS initiated a high-level Practice Improvement Unit, charged with identifying and implementing systematic best-practices efforts throughout the agency and the State substance abuse field.

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- Several new bureaus were created at OASAS during reorganization but no new staff were required; individual staff were instead reassigned and had new reporting relationships – some existing staff reacted well, others reportedly did not.

Key AOD Issues

Strategic Collaboration with other State Departments

- The OASAS Commissioner and the OMH Commissioner are required by statute to meet at least quarterly; there are many other points and frequent contact between the two agencies. At the staff level, there is constant discussion between OASAS staff and OMH staff.
- Being a separate, cabinet-level agency facilitates entrée and continuing interagency collaboration and contacts for OASAS, according to its Executive Team. OASAS has also taken pains not to let this autonomy lead to a silo mentality and it avoids this pitfall through in-depth interagency collaboration.
- The OASAS Executive Team feels it is critical to their interagency efforts for them to be seen as fully equal in rank to other agencies, even those such as mental health that may have larger budgets and more staff.
- OASAS continually collaborates with: the Department of Health/Primary Care regarding its many clients with both infectious and chronic diseases, the adult criminal justice system, and with Corrections, especially on diversion and early release programs in which many eligible substance dependent persons participate.
- There are also active policy and program connections with the Office of Domestic Violence, NYS Medicaid, the Executive Department/Governor's staff, the Office of Child and Family Services, Juvenile Justice, NYS Office of Aging, and others.

Access to Office of Governor and Legislature

- The Governor has a Chief of Staff who is Secretary to the Governor. There are Executive staff members who are specifically assigned to monitor health and human services, including substance abuse. The Executive Deputy for OASAS speaks to them almost daily, as well as to the Deputy Secretary for

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Health and Human Services and the other members of the Governor's Council.

- The OASAS Commissioner also has bi-weekly pre-set meetings with the Governor's Executive office senior staff. The Commissioner sees his role as overall policy setting and leadership. Operational responsibility is delegated to his 5-person Executive Team.
- OASAS executives meet formally and informally with key legislators, especially during budget season and at the annual Joint Budget Hearing. The Commissioner does not normally testify in the legislature; instead, there is an OASAS Assistant Commissioner for Legislative Affairs who has frequent contact with senators and assemblypersons. OASAS' legal counsel, who reports to the Executive Deputy Commissioner and reviews legislation for the agency.
- Each State agency in NY has a legislative committee to which it relates. The NYS Legislature has a standing Alcohol and Substance Abuse Committee to which OASAS provides reports and analyses. Because New York is not a term-limit State, many of the committee members have considerable tenure.
- OASAS interacts frequently with the Senate Finance Committee and the House Ways and Means Committee, in addition to the Alcohol and Substance Abuse Committees. The Commissioner may meet with the Chairs of various legislative program committees as well.
- The NY Senate's Majority Leader has staff members who specialize in health and human services issues and who meet with key OASAS staff as well.
- Prior to the current Commissioner's appointment, there had been some planned restructuring and early retirement incentives during which some staff departed. This freed the current OASAS Commissioner and Executive Deputy to focus on the organizational structure and to use it to target resources strategically, rather than to focus only on reducing personnel. During the reorganization, existing personnel were sometimes reassigned to new duties.

Funding

- OASAS has not been subject to funding reductions that have occurred in States where the substance abuse agency is submerged in another agency or where scarce financial resources are spoken for by the larger constituents of that agency. The Executive Team of OASAS feels it has done relatively well in appropriations due to its autonomy.

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Counties

- New York State's counties are powerful and influential. Making substance abuse policy effectively requires local planning outreach and local planning processes. Counties must provide a 25% Medicaid match so they have a distinct say in Medicaid SA funding decisions and what it supports.

- OASAS has a field office structure that relates to the counties and works with them on an ongoing basis. There is a strong "Home Rule" tradition in the State and heavy reliance on partnership with local government. Again, collaboration is the strategy key for OASAS.

State Data from SAMHSA

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION	2001 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE **	2001 ILLICIT DRUG TREATMENT GAP **	2002 PER 1000 SA TREATMENT ADMISSIONS *	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT $	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	$7.04	6.97	2.02	8.1	1.15	1.16
NEW YORK	$7.41	6.76	2.26	20.0	2.70	2.95

* SAMHSA, Substance Abuse Treatment Admissions by State, 2002

** SAMHSA (OAS) State Estimates of Substance Abuse From the 2001 National Household Survey on Drug Abuse

- New York receives 5% more per capita from the SAPT block grant than the US average (2003).

- The rate of alcohol or illicit drug dependence or abuse in New York is slightly less than the US average (2001).

- The rate of admissions to substance abuse treatment in New York is more than double the US average (2002). Nevertheless, the SAMHSA-defined illicit drug treatment gap is 12% above the national average.

New York Budget and Expenditure Data

- Information obtained from New York indicates a slight increase in substance abuse funding from the 2001/2002 budget year to the 2002/2003 budget

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year. This was followed by a stable level of funding in the 2003/2004 budget year.

- More than half of total public substance abuse funding in New York flows through Medicaid (Data provided here are only for those services and providers that receive NYS OASAS State Aid funding).

- Total funds for substance abuse prevention and treatment in State fiscal year 2003-2004 were $ 1,478.7 million, or $94.41 per capita. These figures include Medicaid ($808.8 million) and local tax funds that support community-based substance abuse services ($45.2 million), public assistance funds to providers that receive NYS OASAS funding ($83.8 million), and private payments to agencies that receive NYS OASAS funding ($89.4 million).

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NORTH CAROLINA

Organizational Placement of AOD Agency

Organization of Office of Substance Abuse

- The NC Chief of Community Policy Management (CPM) is the SSA for substance abuse and the SSA for mental health. The CPM chief has an extensive substance abuse and mental health background. She chaired the Design Committee for ongoing mental health reform.

- There are no separate State substance abuse functions in Division of MHDDSAS.

- There are three specialty substance abuse treatment institutions still managed by a separate Chief of State Operated Services in MHDDSAS.

- There has been stability in the senior staff of the Office of Community Services.

Organization of Services

- Since the end of the 1990's, the MHDDSAS system in North Carolina has been undergoing a complex and carefully planned reform that followed sentencing reform. The impetus for system reform came from press and advocates concerned about symptoms of system

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failure resulting in client deaths in early 1990's. Reform is ongoing. As of 7/1/2004, clinical and management services will be provided through Local Management Entities (LME's), the successor to Community Mental Health Centers. LME's are State bodies responsible for approving, coordinating, and managing services. The State will no longer be a direct provider of community-based services. (The three institutions providing substance abuse treatment services will remain State-owned and managed; these are perceived as regional resources of particular importance to the resource-poor Western portion of State).

- State and block grant-funded community-based substance abuse services are delivered predominantly by non-profits and CBO's.

Impact of Merged Specialty Substance Abuse Function

- Prior to the reorganization of MHDDSAS, there were 35 – 40 FTE staff exclusively focused on substance abuse issues; currently there are 12 FTE staff, each of whom has a partial focus on substance abuse, along with MH and DD functions.
- Staff reductions have greatly increased reliance on contractors, consultants, and other sources of external support.
- Outsourcing of many functions has increased focus on procurement and performance management of external resources.
- One result of reductions in State staff and reliance on external resources has been empowerment of providers, as in Georgia.
- Performance and outcomes management of substance abuse services has become crucial.
- State and LME staff have had to learn new contract management skills.
- The Chief of Community Policy Management believes that merger promotes alignment of approach to service delivery among SA, MH, and DD, while specific elements of policy and operations may differ. She believes this unified approach among services facilitates collaboration with other departments and entities.

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Data and Information

- NC has built an effective data infrastructure over a period of ten years, with Federal and State support. This accomplishment has facilitated system reform. Consistency of State substance abuse leadership in NC is thought to be an important factor in the development of this capability.

- NC also has developed a large human services data warehouse to facilitate data collaboration among various functions.

Access to Office of Governor and Legislature

- The system-reform is effort overseen by a 16 member legislative oversight committee, with equal number of members from House and Senate. The Chief of Community Policy Management works closely with the legislative oversight committee through monthly meetings and frequent conversations. Chief of Community Policy Management also meets with legislative appropriations committees 10-12 times during session.

- The reform efforts were initiated by the legislature, which has a history of strong mental health advocacy, and substance abuse has followed in its path.

- The Governor's wife is leader of Child Alcohol Use Initiative.

- The Governor maintains a MH/ SA/ DD planning office as part of Executive Branch.

- The Chief of Community Policy Management has access to Governor through an informal network.

- NC has a separate Governor's Institute on Alcohol and Substance Abuse, a private corporation.

- The Chief of Community Policy Management works closely with the State budget office. She believes that relationships with State and legislative budget authorities are crucial to successful substance abuse policy.

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- The Chief of Community Policy Management has been entrepreneurial in securing funds from discretionary Federal grants and contracts, the Robert Wood Johnson Foundation, and other foundations to support continued policy initiatives.

State Data from SAMHSA

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION	2001 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE **	2001 ILLICIT DRUG TREATMENT GAP **	2002 PER 1000 SA TREATMENT ADMISSIONS *	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT $	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	$7.04	6.97	2.02	8.1	1.15	1.16
NORTH CAROLINA	$5.72	5.17	1.73	4.4	0.77	0.85

* SAMHSA, Substance Abuse Treatment Admissions by State, 2002

** SAMHSA (OAS) State Estimates of Substance Abuse From the 2001 National Household Survey on Drug Abuse

- North Carolina receives 19% less per capita from the SAPT block grant than the US average (2003).
- The rate of alcohol or illicit drug dependence or abuse in North Carolina is 26% less than the US average (2001).
- The rate of admissions to substance abuse treatment in North Carolina is substantially less than the US average (2002). Nevertheless, the SAMHSA-defined illicit drug treatment gap is 14% below the national average.

North Carolina Budget and Expenditure Data

- Substance abuse funds reported by North Carolina were fairly similar from year to year between State fiscal years 1998 and 2003, except for a significant jump in funding in the years 2001 and 2002. Substance abuse funds in State fiscal year 2003 were 3.5% below those in 2000 and the lowest in six years.
- North Carolina reported a budget allocation of $100.9 million for substance abuse services, including some services provided through Medicaid ($12.7 million), in State fiscal year 2002 – 2003, or $15.13 per capita.

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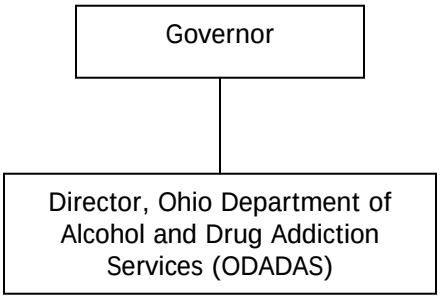
OHIO

Organizational Placement of AOD Agency



- The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) is an autonomous cabinet-level agency.
- The current Director, who previously headed prevention for ODADAS, was appointed 7/12/2003.
- There is a Governor's Advisory Council on Alcohol and Drug Addiction Services, which has recently been strengthened and is moving towards having more of a substance abuse policy recommendation role.

Organization of Services

- Ohio's public substance abuse system is State-administered and locally-operated.
- ODADAS contracts with 43 Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards and 7 specialty Alcohol and Drug Addiction Services (ADAS) Boards in more urbanized areas to deliver prevention and treatment services.
- ODADAS perceives that the 7 ADAS Boards that work specifically on substance abuse services have a much greater focus on substance abuse

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services than do the 43 ADAMHS boards that combine the delivery of both substance abuse and mental health services.

- The local Boards receive funds from ODADAS and also raise some local revenue.
- The majority of funding from ODADAS to the local boards is provided on a per-capita formula basis; a portion – perhaps 15% or so - is provided on a competitive discretionary grant basis.
- ODADAS has a specific number of designated slots on the local boards for which it, through the Governor's office, appoints members.
- Medicaid managed care in Ohio is strictly for physical health. There is no Medicaid managed care for substance abuse or mental health care.

Data and Information

- Since 2000, ODADAS has shared an integrated claims system with the Department of Mental Health.

Key AOD Issues in Ohio

- There is close collaboration with the Department of Mental Health on substance abuse treatment issues for clients under the jurisdiction of Ohio's new mental health courts, which were modeled on the drug courts.
- ODADAS sponsors a fetal alcohol syndrome initiative.
- ODADAS shares prevention initiatives with multiple State agencies.
- ODADAS is planning for possible reduction in State funding due to Ohio's budget deficit.

Collaboration with other State Agencies

- The ODADAS executive team considers that Cabinet-level status is crucial for the launch and success of its many intragovernmental collaborative initiatives, for which there are other competing priorities.

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- ODADAS has numerous ongoing collaborative initiatives with multiple entities, including:
    - Health;
    - Rehabilitation;
    - MR/DD;
    - Aging;
    - Housing;
    - The Lottery;
    - Public Safety;
    - Commerce;
    - Education;
    - Criminal Justice;
    - Economic Development; and
    - Mental Health.
- There are daily communications between ODADAS and DMH.
- The new Director of ODADAS emphasizes the importance and value of collaboration with other agencies and has positive relationship with DMH, whose current DMH Director previously worked in ODADAS.
- ODADAS is active in collaborating with the State's public and private universities in putting together collaborative research projects. Projects are currently in place with Ohio State and Case Western Reserve universities.

Access to Office of Governor and Legislature

- The ODADAS Director attends approximately quarterly Cabinet meetings with the Governor.
- The Director meets with the Governor on ad-hoc basis for briefings and other purposes.
- The Director talks at least weekly to staff in the Governor's office.
- The Director talks weekly with First Lady regarding her advocacy role for alcohol abuse issues.

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- The ODADAS legislative liaison meets weekly with counterparts from other Cabinet-level Departments in the Governor's office.
- The Director meets with key legislators at least monthly.
- The new Director has emphasized importance of closer communication with Governor and Legislature.

Internal Departmental Restructuring

- ODADAS has recently restructured to enhance efficiency and effectiveness. The following Divisions have been created:

    - Quality Improvement
    - Planning, Outcomes and Research
    - Treatment and Recovery
    - Prevention Services
    - Fiscal Services
    - Management Information Services
    - Fiscal Services

  Additionally, the Director has the following functions reporting to his office:

    - Communications and Training (moved in house from contractors)
    - Assistant Director
    - Legislative Liaison
    - Administration
    - Chief Counsel

Entrepreneurial Attitude

- Ohio describes itself as having an assertive, entrepreneurial attitude towards finding new sources of funding for substance abuse prevention and treatment, often obtained through collaboration with other departments and universities.
- Ohio is also actively pursuing every Federal grant it can find to help provide substance abuse funding.

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- Ohio has a substance abuse benefit under Medicaid and has TANF-funded programs for substance abusing mothers who are trying to find paid employment. Services covered include inpatient detoxification, general hospital outpatient AOD services, IOP, counseling, methadone, and case management services.

State Data from SAMHSA

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION	2001 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE **	2001 ILLICIT DRUG TREATMENT GAP **	2002 PER 1000 SA TREATMENT ADMISSIONS *	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT $	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	$7.04	6.97	2.02	8.1	1.15	1.16
OHIO	$7.22	6.27	1.69	5.1	0.70	0.81

* SAMHSA, Substance Abuse Treatment Admissions by State, 2002

** SAMHSA (OAS) State Estimates of Substance Abuse From the 2001 National Household Survey on Drug Abuse

- Ohio receives slightly more per capita from the SAPT block grant than the US average (2003).
- The rate of alcohol or illicit drug dependence or abuse in Ohio is 10% lower than the US average (2001).
- The rate of admissions to substance abuse treatment in Ohio is about 37% lower than the US average (2002). Nevertheless, the SAMHSA-defined illicit drug treatment gap is 16% below the national average (2001).

Ohio Budget and Expenditure Data

- Expenditures for substance abuse services in Ohio increased from $281.6 million in State fiscal year 2000 to $305.2 million in 2002, an increase of 8.4%.
- Ohio spent $33.47 per capita on substance abuse services in State fiscal year 2002. This figure includes Medicaid, which accounts for one-third of the ODADAS budget.

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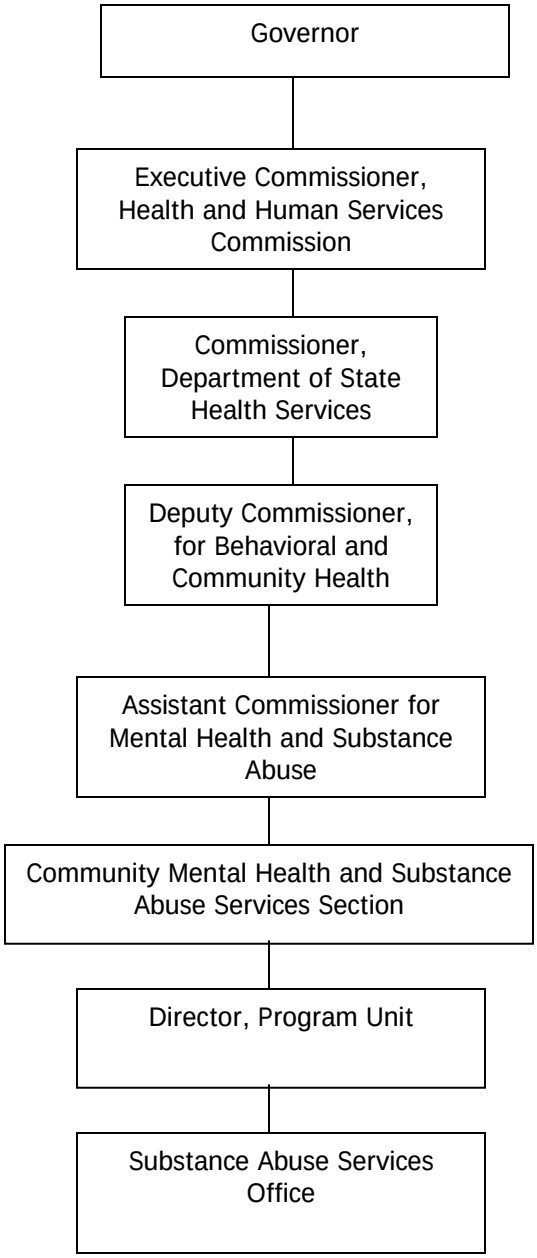
TEXAS

Organizational Placement of AOD Agency



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Organizational Placement of Substance Abuse After 2003 - 2004 Reorganization

- The current Executive Director of the Texas Commission on Alcohol and Drug Abuse (TCADA), who also served 14 years in the State MH department, was promoted in May '04 to be new Deputy Commissioner for Behavioral and Community Health for the Department of State Health Services (DSHS).

- Historically, TCADA had its own Board of Directors appointed by the Governor. This Board and 12 other agency-specific boards will be discontinued in September 2004 as part of the Texas State government health and human services reorganization. There will now be one, 9-member advisory committee for the whole HHSC and the four agencies reporting to it, including the Department of State Health Services (which houses mental health and substance abuse), the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services, and the Department of Family and Protective Services.

- The TCADA Director reported to the TCADA Board and through deputies to the Commissioner of Health and Human Services. In the new structure, the Division and the Director will report to the new Deputy Commissioner for Behavioral and Community Health and through that person to the Commissioner of the Department of State Health Services (DSHS), who in turn reports to the newly elevated and appointed Executive Commissioner of Health and Human Services.

- The former Mental Health Director retired in February 2004 and an interim Commissioner is serving until the new Director of the consolidated Division takes over in September 2004. There will be no longer be a separate mental health Director or a separate substance abuse Director at the Division or Unit Level.

- In the recent reorganization, which began in June 2003 and will be fully implemented on September 1 2004, 12 Health and Human services-related agencies were consolidated into the 4 Departments noted above.

- The Department of State Health Services, headed by a Commissioner, who is a physician specializing in family practice and public health, is the new home for both mental health and substance abuse. DSHS will have four divisions (Division of Mental Health and Substance Abuse,

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Division for Family and Community Services, Division for Prevention and Preparedness, and the Division for Regulatory Services).

- The impetus for the change coincided with the changes in the political composition and direction of the Texas Legislature and the election of a new Governor. External consultants from at least two consulting firms were involved, but much of the analytical work is being done by State employees who are appointed to a special reorganization task force, as in CA. One of the individuals formerly involved in the Texas reorganization is now working with the California Performance Review taskforce.

Organization of Substance Abuse Services

- The new Substance Abuse Services office will be part of the Community Mental Health and Substance Abuse Services Section, reporting to the consolidated Division Director, whose title is Assistant Commissioner for Mental Health and Substance Abuse. Functions for the section include contract management, quality management and programs.

- SA services office will be nested lower than before, but is at an equivalent level with the Mental Health office (Mental Retardation Services were moved out of Mental Health and placed in the Department of Aging and Disability Services), the consolidated MH/SA Contract Management Unit and the consolidated MH/SA Quality Management Unit. Psychiatric hospitals are separate from these units and are part of the new State Hospitals Section that reports to the Division Director.

Relationship to Mental Health Unit

- Mental health and substance abuse are now equivalent, lower ranking offices with lower ranking Directors, both reporting to the Director of the Community Mental Health and Substance Abuse Services Section, which, like the new Hospitals Section, reports to the Director of the newly consolidated Division for Mental Health and Substance Abuse.

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Access to Office of Governor and Legislature

- The TCADA Director is by statute also the chair of the State's Drug Demand Reduction Advisory Council. The Drug Demand Reduction Council was created by the Legislature in 2001 and is directed to serve as a single source of information for the governor, the legislature, and the public about issues relating to reducing drug demand, including available prevention programs and services. It is also charged with developing a statewide strategy to reduce drug demand.

- TCADA formerly worked closely with the Legislative Budget Board and, because of its close management and its contemporary web-based clinical records and billing system, has been recently regarded within TX State government as having been far more efficient and accountable since 2001 than it was previously. A number of the other State agencies are either assessing or considering using this TCADA information system, an adjusted version of which has migrated nationally to SAMHSA and other States in the form of the Web Infrastructure for Treatment Services (WITS) system.

- The TCADA Director, soon to be the new Deputy Commissioner for Behavioral and Community Health, works frequently with the House Appropriations Committee, the Senate Finance Committee and other legislative committees.

- However, since 90% of TCADA's funding is Federal, there is concern that the State must continue to pay attention to its SAPT block grant and to SAMHSA reporting requirements.

Interagency Relationships and Collaboration

- TCADA, with the Texas Department of Mental Health and Mental Retardation, oversees the highly visible NorthSTAR Medicaid managed behavioral health program, using an external, private-sector vendor to provide day-to-day operations and management.

- TCADA works with many other State agencies and views interagency collaboration as a second major tool to accomplish its mission, along with data collection and reporting. Collaborations include those with mental health, labor, child protective services, juvenile justice, education, the criminal justice system, judicial system, and law enforcement agencies.

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- TCADA works collaboratively with SAMHSA is actively pursuing Federal grants.

- Interagency relationships, post reorganization, are implemented via Memoranda of Understanding.

Executive Leadership

- For the last four years, TCADA has had a stable, experienced and highly educated Executive staff, both at the Director level and at the senior management level. One member of the senior management team has participated extensively on the Texas government reorganization taskforce.

- TCADA has a statutorily required Statewide Service Delivery Plan outlining the most effective and efficient manner to address substance abuse service needs throughout Texas (TCADA also produced an extensive Annual Report in 2002).

- TCADA's fourth Statewide Service Delivery Plan, promulgated in February 2004, is expected to remain in force under the reorganization. It focuses on six key strategies, including:

    - Enhancing needs' assessment and data-based decision-making, and accessing Federal and foundation grants to better assess and address needs;

    - Implementing disease management programs' and research-based practices for prevention and treatment;

    - Conducting a Statewide procurement of all prevention and treatment services, including new services, and achieving funding equity of services, and purchasing and monitoring services for quality and cost;

    - Adopting and implementing new rules, including uniform Standard of Care rules, for all clinical licensees;

    - Increasing focus on outcomes' data for providers;

    - Providing leadership in partnerships with other agencies and organizations.

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Although the essence of the 2004 plan will not change under the new structure, it may have to be adapted to address HHSC or DSHS issues and strategic priorities as they arise. In addition, TCADA has improved the substance abuse provider reimbursement rates.

State Data from SAMHSA

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION	2001 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE **	2001 ILLICIT DRUG TREATMENT GAP **	2002 PER 1000 SA TREATMENT ADMISSIONS *	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT $	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	$7.04	6.97	2.02	8.1	1.15	1.16
TEXAS	$7.80	6.86	1.83	2.1	0.27	0.30

* SAMHSA, Substance Abuse Treatment Admissions by State, 2002

** SAMHSA (OAS) State Estimates of Substance Abuse From the 2001 National Household Survey on Drug Abuse

- Texas receives 10.8% more per capita from the SAPT block grant than the US average (2003).
- The rate of alcohol or illicit drug dependence or abuse in Texas is slightly less than the US average (2001).
- The rate of admissions to substance abuse treatment in Texas is substantially less than the US average (2002). Nevertheless, the SAMHSA-defined illicit drug treatment gap is 9% below the national average.

Texas Budget and Expenditure Data

- Information obtained from Texas indicates a 10.2% increase in substance abuse funding from the 2001 budget year to the 2003 State fiscal year, increasing from $143.6 million to $158.3 million.
- Substance abuse funds were $9.25 per capita in State fiscal year 2003.
- Texas spends 37% of its funds for alcohol and drug abuse for primary prevention and HIV early intervention services.

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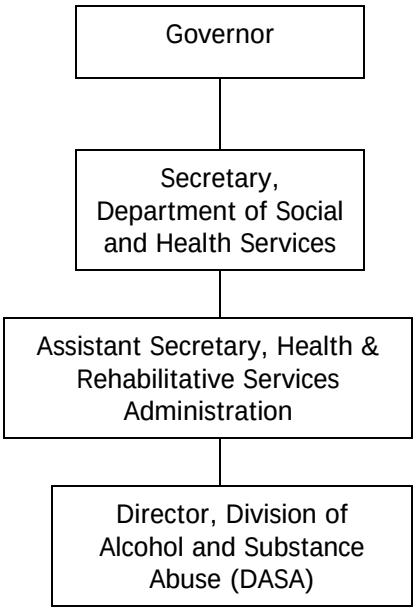
Organizational Placement of AOD Agency



Organization of Services

- DASA contracts with 39 counties to deliver prevention and outpatient treatment services.
- DASA holds its own contracts directly with residential treatment providers and inpatient services, considered a statewide resource, as well as with Indian Tribes.
- Along with DASA, two other agencies have AOD prevention responsibility:
    - Community Trade and Economic Development (Byrne law enforcement funds, RSAT, Safe and Drug-Free Schools-governor's portion)
    - Supervisor of Public Instruction (Safe and Drug-Free Schools)

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Core Strategic Initiative: Data and Information

- Data and information systems are the core strength of DASA and the foundation of its strategy to demonstrate impact of services, document accountability and achieve credibility within its Department, with other agencies and within the State and U.S.

- The State utilizes a variety of mechanisms to measure substance abuse prevalence, trends, impact, prevention, treatment, and treatment outcomes. Among the data systems used are the following:

    - A reporting management information system required for treatment agencies providing public-sector contracted treatment services. Information is collected for each client to provide a baseline at admission to treatment and capturing changes to that baseline upon discharge.

    - A biannual survey of adolescent health behaviors conducted under the auspices of the Superintendent of Public Instruction.

    - A comprehensive hospital patient data abstract reporting system.

    - A variety of special studies and surveys conducted by DASA.

- Ongoing cost-offset studies produced by DASA have been a key strategy to document outcomes of substance abuse treatment in Washington State. Such offsets include avoiding crime and incarceration, limiting utilization of acute health care and psychiatric services, and reducing reliance on public assistance and getting people back to work, that is, employment.

- State legislators and other policy makers are more receptive to evidence based on Washington State data than on national or other State studies, so DASA's focus is on Washington State trends and reports.

- Annual DASA report - **Abuse Trends in Washington State** – a 325 page book - is an important accountability tool.

- DASA's MIS system, which tracks patients in the publicly funded system, is also used by the Department of Corrections to track individuals under its supervision who receive substance abuse treatment.

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- DASA separated Policy and Planning from Research five years ago to facilitate focusing research on demonstrating the impact of AOD services.
    - Policy and Planning and legislative relations activities have 6 FTEs, who are responsible for Block Grant reports and similar activities
    - The research activity has 1 FTE plus 3 FTE's on "soft" (grant-funded) money
- The Director emphasized that stigma of substance abuse still extends to those who provide, manage and advocate for SA treatment. This stigma can only be addressed by being able to demonstrate the degree of effectiveness of SA treatment and its impact on other State systems and communities, using valid ongoing data collection and rigorous research techniques on topics of policymaking interest.

Sentencing Reform: A Significant Policy / Organizational Change in Previous Three Years

- Sentencing reform in Washington, enacted in 2002, reduced the length of sentences for heroin and cocaine possession or small-scale sales and provided that savings from reduced incarceration be used to fund drug treatment, including drug courts.
- This legislation was supported by DASA.
- The program was implemented despite a 10% DASA staff reduction in 2002.
- The initiative was supported by prosecutors and other components of the criminal justice system, including judges and the defense bar
- The program brought an infusion of funds to public substance abuse treatment, with an increase of about 4% annually.
- The client population for this initiative is primarily single men – not the population for which WA has developed the strongest evidence of the impact of AOD treatment through cost-offset studies.
- The initiative has significant accountability requirements and requires careful management.

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Washington State "Drug Czar" Phased out in early 1990's

Key AOD Issues in Washington State Today

- State Reorganization Plans
    - Washington Governor Gary Locke, first elected in 1996, has announced that he will not seek re-election. A new Governor will be elected in November 2004 and may want to re-shape State government in order to address new priorities.
- Increase Penetration of Treatment
    - Develop an entitlement strategy through Medicaid for providing substance abuse treatment services to priority populations – pregnant women and SSI recipients.
- Evidence-based prevention
    - Increase the funding for State prevention activities that have strong scientific evidence of effectiveness.

Collaboration with other Entities

- Collaboration is considered necessary to accomplish the strategic objectives of the Division.
- It is expected that collaboration brings on workload. AOD staff are encouraged to "do the work" in collaborative efforts and allocate time accordingly. This strategy assures that DASA is able to incorporate its priorities and objectives when engaging in collaborative efforts.
- DASA staff is encouraged to collaborate with other public/State entities as well as private sector organizations, such as provider groups.

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Access to Office of Governor and Legislature

- The DASA Director believes that substance abuse issues rarely rise to the top of DSHS priorities. DASA must take the lead in raising the visibility of SA issues.
- The stability of DASA's leadership group and the strength of the DASA data system have facilitated productive connections with the Governor's Office, other State/public agencies, and the Legislature.
- DASA staff have weekly contact with staff of the Governor's Office and more frequent telephone calls.
- DASA has frequent contact with other agencies, including:
    - Key House legislator and staff;
    - Key Senate legislator and staff;
    - The Director of WA Association of Prosecuting Attorneys; and
    - The Director of the Department of Corrections.
- The frequency of meeting with external stakeholders is driven by policy and budget exigencies. The Governor's Office has emerged as a key stakeholder, but two years ago legislators and legislative staff were key stakeholders.

State Data from SAMHSA

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION	2001 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE **	2001 ILLICIT DRUG TREATMENT GAP **	2002 PER 1000 SA TREATMENT ADMISSIONS *	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT $	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	$7.04	6.97	2.02	8.1	1.15	1.16
WASHINGTON	$7.13	8.37	2.41	10.6	1.49	1.27

* SAMHSA, Substance Abuse Treatment Admissions by State, 2002

** SAMHSA (OAS) State Estimates of Substance Abuse From the 2001 National Household Survey on Drug Abuse

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- Washington receives slightly more per capita from the SAPT block grant than the US average (2003).

- The rate of alcohol or illicit drug dependence or abuse in Washington is 20% higher than the US average[12].

- The rate of admissions to substance abuse treatment in Washington is about 31% higher than the US average[13]. Even so, the SAMHSA-defined illicit drug treatment gap is 19% above the national average[14].

State Budget and Expenditure Data

- The Division of Alcohol and Substance Abuse had expenditures of $93.4 million in State fiscal year 2003, or $18.96 per capita. These figures include funds from Medicaid.

- State funds make up 60% of the DASA budget.

[12] SAMHSA (OAS) State Estimates of Substance Abuse From the 2001 National Household Survey on Substance Abuse
[13] SAMHSA, Substance Abuse Treatment Admissions by State, 2002
[14] SAMHSA (OAS) State Estimates of Substance Abuse From the 2001 National Household Survey on Substance Abuse

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TABLE IV

SUMMARY OF STATE DATA FROM SAMHSA

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION	2001 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE **	2001 ILLICIT DRUG TREATMENT GAP **	2002 PER 1000 SA TREATMENT ADMISSIONS *	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT $	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	$7.04	6.97	2.02	8.1	1.15	1.16
CALIFORNIA	$9.01	7.58	2.68	7.5	0.83	0.99
FLORIDA	$6.83	6.54	1.69	6.3	0.92	0.96
GEORGIA	$6.97	6.01	1.77	5.0	0.72	0.84
MASSACHUSETTS	$6.47	9.13	2.54	12.8	1.98	1.40
MICHIGAN	$7.15	7.14	1.99	7.8	1.09	1.10
NEW YORK	$7.41	6.76	2.26	20.0	2.70	2.95
NORTH CAROLINA	$5.72	5.17	1.73	4.4	0.77	0.85
OHIO	$7.22	6.27	1.69	5.1	0.70	0.81
TEXAS	$7.80	6.86	1.83	2.1	0.27	0.30
WASHINGTON	$7.13	8.37	2.41	10.6	1.49	1.27

* SAMHSA, Substance Abuse Treatment Admissions by State, 2002. Note that some States report data only on providers who receive State-funded admissions; others report on all providers regardless of sources of funding.

** SAMHSA (OAS) State Estimates of Substance Abuse From the 2001 National Household Survey on Drug Abuse

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APPENDIX

DISCUSSION GUIDE AND STATE EXPENDITURE INFORMATION REQUEST

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AOD ORGANIZATION STUDY

In this study, we are interested both in adults and children with AOD issues. Please address both of these populations in your responses to the questions on the following pages.

Proposed Informants for each State:

- SSA AOD Director
- SSA AOD Finance Chief
- SSA AOD Policy Chief or Department Staff Responsible for Legislative Issues
- Principal AOD Legislator; to be identified by AOD Director. This is the member of the State Legislature most responsible for AOD budget and policy issues. Although this individual may not be available during the timeframe for this initial study, we will attempt to obtain contact information for use in arranging a future interview.

These questions are intended to be asked either in person or over the telephone. Some questions will not apply to you or your organization. **Written responses are not requested.** We will request appropriate available documents and data in the course of our discussion.

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INTERVIEW QUESTIONS

I. Position of SSA for AOD in State Organizational Structure

A. To what State entity or official does SSA for AOD report directly? Is AOD a Cabinet level Department? Does AOD report to any of the following, and if so, please explain the relationship:

1. Governor
2. Department of Human Services
3. Department of Health
4. Department of Mental Health
5. Other

B. Please provide an organizational chart showing the position and relationship of AOD, Mental Health and Health within the State structure.

C. What changes in State organizational structure that affect AOD have taken place in each of the last three years?

1. 2001?
2. 2002?
3. 2003?
4. 2004 to date?

D. Who were the individuals most responsible for pushing any changes forward in each of the last three years? What are their backgrounds and titles, if relevant? Please explain the dynamics of any changes – proponents and their rationale; opponents and their rationale.

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II. Organization of AOD Department

A. Please provide an internal organizational chart for the AOD Department / Agency

B. What are the most important changes in the internal organizational structure of the AOD Department / Agency that have occurred over the past three years?

III. Inter-Organizational Relationships

A. Relationship to Governor

1. How often does AOD Director meet with Governor?

- Annually?
- Semi-Annually?
- Quarterly?
- Monthly?
- Other?

2. How often does AOD Director talk on telephone to the Governor or meet with Executive office senior staff?

- Annually?
- Semi-Annually?
- Quarterly?
- Monthly?
- Other?

B. Relationship to Legislature

1. How often does Director of AOD meet with key legislator(s)?

- Annually?

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- Semi-Annually?
- Quarterly?
- Monthly?
- Other?

2. How often does AOD Director meet with appropriations committee?

    - Annually
    - Semi-Annually?
    - Quarterly?
    - Monthly?
    - Other?

C. Relationship to Department of Mental Health

1. How often does AOD Director meet with Director of Mental Health?

    - Annually?
    - Semi-Annually?
    - Quarterly?
    - Monthly?
    - Other?

2. How often does AOD Director talk on telephone to the Director of Mental Health?

    - Annually?
    - Semi-Annually?
    - Quarterly?
    - Monthly?

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- Other?

3. How many collaborative programs do the AOD Department and the Department of Mental Health have?

4. How many joint committees do the AOD Department and the Department of Mental Health have?

D. Relationship to the Executive Office of the Budget

1. With whom does the AOD Director interact on budget matters and decisions? If it is the State Budget Director, how often does AOD Director meet with Budget Director?

   - Annually?
   - Semi-Annually?
   - Quarterly?
   - Monthly?
   - Other?

2. How often does AOD Director talk on telephone to Budget Director?

   - Annually?
   - Semi-Annually?
   - Quarterly?
   - Monthly?
   - Other?

E. Other Relationships

1. What other collaborative relationships and programs toes AOD have with other agencies / programs?

   - Social Services?
   - Criminal Justice / Corrections?
   - CDC?

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- Health?

IV. For States where there has been a change in the position of AOD in the State organizational structure:

A. Reasons for Change

1. What was the impetus for the change? Were there changes in each year from 2000-2004 or just this year?

2. Were external consultants involved in the change? Who were/are they?

3. Was there a single individual or interest group that was primarily responsible for the change?

4. Was information system consolidation a reason for the change?

5. Were State budget problems a reason for the change?

6. Were rising Medicaid costs a reason for the change?

7. Was change a result of a rethinking of the role of AOD services in the human services or health system?

B. Impact of the change in the position of AOD in the State organizational structure [fiscal (e.g., modification to reimbursement rates/contracts), programmatic (e.g., change in provider qualifications/expectations, or service delivery), or capacity (e.g., # of providers changed)]:

1. To what extent did the governance of the AOD department change as a result of restructuring?

   - How did mental health and AOD align potentially differing Federal and State statutory / regulatory authority?

2. What was the impact on AOD providers?

3. What was the impact on AOD programs?

4. Were any State-supported AOD programs opened or closed?

5. What was the impact on clients?

   - Men vs. Women?

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- Adults vs. Children
- Clients with Co-Occurring disorders?
- Clients with primary AOD disorders?

6. What was the impact on AOD Department staff morale?
    - Was there any impact on retention of senior civil service staff?
    - Were there voluntary or involuntary departures of key personnel? Is the Director of AOD a new staff member?
7. Was there any impact on the ability of the AOD department to comply with Federal regulations?
    - Was there any impact on the ability of AOD to meet Federal MOE requirements? If so, how was this issue resolved?
8. Was there any impact on the relationships with and the access to key Legislators, the Governor and key members of the Executive department?
9. Was there any impact on inter-organizational relationships – the relationships of AOD to other agencies / departments?
    - Was there any impact on the relationships between AOD and criminal justice, Medicaid, Public Welfare, or Mental Health?
10. Was there any impact on access to external resources?
    - Consultants
    - Medical Experts
    - Other
11. Was there an impact on policy priorities?
    - Within the AOD Department
    - Among HHS departments / agencies

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12. Was there any impact on the quantity of services provided or offered to public program recipients?

13. Was there any impact on the quality of services provided or offered to public program recipients?

14. Were there any savings attributable to the organizational position change?

15. What was the impact of the change on outcomes?

16. What were the goals of the change and have they been met?

17. Was there an impact on the ability to access Federal resources, including the SAPT block grant?

18. Was there an impact on the ability to access State resources?

19. Was there an impact on the relationships with and the amount of collaboration with other State departments / agencies?

20. What impact did the change have on the relationship of the AOD Department with the MH Department?

V. Structure of Treatment System

A. Reliance on Methadone

1. What proportion of AOD expenditures are for medication-assisted treatment, including methadone treatment? What proportion for methadone treatment?

2. What is the distribution of public vs. private OTPs and treatment slots in your State?

B. County and local treatment

1. What is the role of county and local political structures in your treatment system? Do State and Federal AOD funds flow to county and local political entities?

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State Expenditure Information Request

A. Please provide the total AOD expenditures for all departments of State and county / local government combined for the past three years, including expenditures from funds received from the Federal government. If possible, include expenditures from other departments, such as Social Services, Health, Mental Health, Corrections / Criminal Justice, and Public Welfare and Medicaid. Use the following categories of AOD spending:

1. Substance Abuse Treatment and Rehabilitation
2. Alcohol Treatment and Rehabilitation
3. Drug Treatment and Rehabilitation
    - Detoxification (24 Hour Care)
    - Residential (Hospital Inpatient, Short Term, Long Term)
    - Ambulatory / Outpatient
        - Methadone
        - Non-Methadone
        - IOP
        - Detox
4. Primary Prevention
5. TB Services
6. HIV Early Intervention Services
7. Administration (Excluding Program / Provider)

B. Please provide the total expenditures for the following State departments for the past three years, including expenditures from funds received from the Federal government. Please identify and specify AOD block grant funds.

1. AOD
2. Mental Health
3. Health

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